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Use of Child Welfare Manpower

Welfare and Medical Services

The Hospital—the Child's View

Children Learning From Children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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The Efficient Use of Child Welfare Personnel . 91
Donald Brieland

Improving Coordination of Welfare and Medical Services 97
Margaret A. Dennis

The Hospital Through a Child's Eyes 102
Martha L. Adams and Dorothy C. Berman

A Preschool Program for Children With Cerebral Palsy 105
Malinda G. Gay

Working With Children Who Won't Go to School 109
I. N. Berlin

Cross-Age Relationships — An Educational Resource 113
Peggy Lippitt and John E. Lohman

Unmarried Mothers Who Kept Their Babies . . 118
Ellery Reed

Here and There 120
Book Notes 125
In the Journals 126
Readers' Exchange 127

LEARNING TO READ is an obviously exciting adventure for these two children in a preschool center for cerebral palsied children. How one such center recognizes in its admission policies the importance to even the most severely handicapped children of having opportunities to learn whatever physical, social, and communicative skills they can master is described in the article beginning on page 105.

A psychologist whose major interests are public administration and child welfare research, **Donald Brieland** has headed the Illinois child welfare program since 1961. Previously director of the Elizabeth McCormick Fund, which specializes in child health studies, he has taught at Northwestern University and at the University of Minnesota.

A graduate of the McGill University School of Social Work, Montreal, **Margaret A. Dennis** has practiced as a medical social worker in the United States, Canada, and England. She took her present position at New York Hospital in 1961. A previous paper by Miss Dennis on other aspects of the project described has appeared in *Social Casework.*

Martha Adams (left) and **Dorothy Berman** became interested in children's reactions to hospitalization while supervising Boston University School of Nursing students caring for children in a hospital. Miss Adams is now assistant professor in maternal and child nursing, University of California School of Nursing. Mrs. Berman once worked with deaf and mentally retarded children.

In addition to working with cerebral palsied children at the preschool center she describes, **Malinda Gay** is doing graduate work in exceptional education at the State University of New York, College of Education, at Buffalo. With a B.S. in education, she is certified both as a teacher in art and as a teacher of physically handicapped children.

Since writing his article, **I. N. Berlin** has left California—where for 15 years he gave school psychiatric consultation—to go to the State of Washington, to become professor of psychiatry and director of the division of child psychiatry, University of Washington School of Medicine. His interest in learning problems stems from his work with schizophrenic children at the Langley Porter Neuropsychiatric Institute, California State Department of Mental Hygiene.

Peggy Lippitt, who received her master of education degree at the University of California, Los Angeles, has taught at the University of Michigan Laboratory School. She is now coordinator of the cross-age demonstration project described in the article. **John Lohman,** a social psychology doctoral candidate at the university, conducts research in several types of peer cultures.

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Some suggestions for coping with the manpower paradox through . . .

THE EFFICIENT USE OF CHILD WELFARE PERSONNEL

DONALD BRIELAND

Director, Illinois Department of Children and Family Services

THE MANPOWER PROBLEM is a dominant concern today in all the fields of service to people. Public child welfare programs are among those faced with an urgent necessity to find creative solutions. The goal set for these programs by the 1962 amendments to the Social Security Act is to achieve full geographic coverage with professionally trained staff by 1975. This entangles them in a paradox. The rapid rate of program expansion is resulting in a continuing decrease in the proportion of professional staff to total staff, even though the number of professionals increases. Thus the programs must move in what seems to be two directions at once—the protection or improvement of the quality of service and the rapid extension of coverage to all children needing service.

The provisions of the Economic Opportunity Act of 1964 add to the urgency of the problem. Its antipoverty programs will make the shortage of professional personnel more acute by creating more job opportunities for professional social workers. At the same time, these programs will include many community projects in which social service functions will be performed without the use of professional social workers, either in direct service or supervisory positions. A number of these programs will focus on the "culturally deprived" child and will be of concern to State and local officials responsible for child welfare.

The key to the manpower problem in social services may lie in the way personnel is used as well as in a broader conception of staff development. The Children's Bureau sponsored a meeting on the use of case aides in 1959. More recently, the National Association of Social Workers has developed a theoretical model for the use of personnel.[1] The NASW has also undertaken some pertinent activities with the U.S. Department of Health, Education, and Welfare: development of demonstration project designs in differential use of staff with the Bureau of Family Services; and the sponsorship of a research conference on manpower with the Children's Bureau. The Bureau of Family Services has been working on proposals for multiple career lines in public family services as an outgrowth of an educational standards project begun in 1959. And DHEW has issued a publication summarizing the need for research in social work manpower.[2]

A Wisconsin committee drawn from the field of public welfare and the schools of social work recently identified six points of difficulty which underscore the need for new approaches to the use of available personnel.

In brief the points are:

1. The production of professionally prepared social workers is not meeting and never will meet growing staff needs.

2. The personnel gap has been and will continue

to be bridged by the appointment of staff who do not have the master's degree.

3. Tasks assigned to nonprofessional and professional staff tend to be identical.

4. Professional staff have been expected to perform tasks for which they are "over educated."

5. Some elements in concepts of the supervisor-worker and client-worker relationships block experiments in the differential use of personnel.

6. Inflexibility in staff usage also stems from the idea that all tasks of case service should be performed by a person with maximum skill, so that every diagnostic and treatment potential can be exploited.

In an unpublished statement, the committee emphasized the interlocking responsibilities of the social work profession, schools of social work, and social welfare agencies for seeking solutions to the problem. It maintained:

Solutions to the manpower problem can only occur if serious study is undertaken of the demands of the job of casework service, while holding in abeyance any traditional concepts of the job which have mitigated against experimentation. Further solution to the personnel and training aspects of the manpower problem can be advanced only as innovated efforts are designed in a framework of cooperation and collaboration. Any proposed solution must, therefore, touch base with the problems of task differentiation, personnel policies and practices, administrative organization, education and training, and conversion from the current pattern to more effective patterns.

Differential Staff Use

What is involved in the differential use of manpower?

While the general goal is to provide more service more effectively, there are important subgoals:

1. To maximize the contribution of professionally trained workers.

2. To facilitate efficient and rapid development of skills for younger professional workers.

3. To utilize the energies of workers who have only bachelor's degrees, so that they are engaged in the tasks most adequately suited to their skills.

4. To differentiate roles and tasks to make possible the most efficient orientation and staff development programs.

5. To put as much effort as possible into direct services to children and families without neglecting the obligation for reporting.

6. To provide staff at all levels with career lines, a sense of status and responsibility, and an agency climate that will result in good morale and a high rate of staff retention.

The fear is always expressed that experimentation to reach these goals will dilute professional functions and impair service. However, many of the functions now carried on by professional staff members are subprofessional in nature. Differential use of manpower should free the professional to use his special skills more widely.

In the child welfare field, the manpower problem is often considered at only two levels, the professional caseworker and the worker with only a bachelor's degree. However, at least eight different personnel categories can be considered for purposes of manpower research.

These eight categories are:

1. Caseworkers with a master's degree in social work as their minimum qualification.

2. Persons with a master's degree (or higher) in related fields.

3. College graduates with casework experience.

4. College graduates with no experience but with an interest in child welfare and perhaps in graduate social work education.

5. Foster parents and others from whom the agency may purchase service.

6. Clerical employees, generally with a high school education or above.

7. Volunteers representing wide variation in interests, education, and skills.

8. Former public assistance or child welfare clients.

In projects aimed at the more efficient use of manpower in child welfare programs, it is appropriate to involve not only supervisory and casework staff, with and without professional training, but clerical personnel as well. Some of the tasks being performed by caseworkers can probably be assigned to clerical personnel.

It is also important to consider volunteers—what roles they now play, what they can do, and how they can be recruited. The creative use of volunteers promised in the community action programs under the Economic Opportunity Act may provide useful examples for child welfare agencies, which rarely use this source of supplementary manpower.

Three specific suggestions to assist in differential use of manpower need serious exploration: (1) the development of teaching materials for nonprofessionally trained staff who have bachelor's degrees; (2) special training programs for workers too isolated to participate fully in a team; and (3) a team approach to public child welfare functions.

Teaching Materials. Indirect teaching methods, such as theoretical discussions, are not sufficient for training subprofessional child welfare staff. Workers need to observe and participate directly in activities that illustrate skill in practice. Especially helpful in this connection are films and tape recordings of agency activities and interviews involving various aspects of the child welfare programs, such as child placement, services to children in their own homes, court hearings, services to unmarried mothers, and day care. Through such materials, new approaches being tried in both tax-supported and voluntary agencies, as well as the traditional methods of providing services, can be illustrated.

The use of such materials should be supplemented by opportunities for subprofessionals to participate with qualified senior workers in actual interviews with clients. Fortunately, many of the objections to using audiovisual devices and joint interviewing—based on an exaggerated conception of confidentiality—have been overcome.

So far, public child welfare agencies have made little use of modern devices to develop examples of primary process. A few experiments have been carried on, mainly in schools of social work. There, the need is much less than in public agencies, where many workers have not had the exposure to graduate school and field training.

One of the most promising suggestions for the field of public welfare is the establishment of a teaching materials center which would produce films, tapes, and teaching guides, and collect case records and other teaching materials to be made available to public welfare agencies at cost. The recent award of a $30,000 grant from the Field Foundation to the Council on Social Work Education indicates that such a center will soon get under way.

Educating the Isolated Worker. Many counties do not have any professionally trained public child welfare workers, and, realistically speaking, will not have any in the foreseeable future. In some of these counties, staff members are isolated by distances or by county jurisdictions and thus are kept from receiving adequate professional supervision or from participating in a team made up of both professional and nonprofessional workers.

These isolated workers often have valuable assets, especially since they are usually well-informed about their communities. Regardless of their lack of professional training, they are considered to be child welfare experts by judges, public health nurses, school personnel, and other local leaders; and indeed their experience and judgment may make them experts.

Such personnel need frequent opportunities for on-the-job education. Mobile training units can be developed. Also, groups of workers from smaller counties can be brought together for formal training courses and for sharing experiences and receiving consultation on actual cases. In addition to profiting from consultation from professionals, workers can help each other learn. A teaching materials center could provide valuable help for both group activities and individual self-instruction.

The Team Approach. The team approach provides for the close working together of professionally trained and subprofessional workers, with the responsibilities of each clearly defined by the agency. A prerequisite of this approach is a careful analysis of the tasks involved in the agency's services, followed by a continuing staff development program for all agency personnel.

Some Experiments

A few experiments are already under way, aimed at more efficient use of available child welfare staff.

One approach is to differentiate fact-finding tasks from other child welfare functions and to train persons with a bachelor's degree to carry them out. For example, the Jane Addams Graduate School of Social Work, University of Illinois, with the use of Federal funds from the Children's Bureau, has analyzed the tasks involved in licensing independent foster homes and foster day-care homes and has trained nonprofessionals for them.[3]

Much effort has gone into the creation of public child welfare agencies of short-term trainee positions for college graduates, giving them a chance to practice casework and then go on to graduate school on stipends provided by the agency through the use of Federal child welfare services funds. This has the advantage of giving both the student and agency a trial period. An analysis needs to be made of the performance of trainees who have majored in social welfare in an undergraduate college, compared with

the performance of those with other educational backgrounds.

Much effort has also been expended in staff development programs for trainees and for regular child welfare staff members who hold only a B.A. degree. Generally, the two programs differ in content because the trainees are in transition between college and graduate school and the regular workers are being trained primarily for immediate responsibilities in the agency.

Most State child welfare directors can point to informal, pragmatic efforts in local units to develop criteria for the assignment of cases based on levels of training. The general guidelines vary, depending on the insight and teachability of the individuals. Few of the projects have been described in print. Pertinent, however, for the child welfare field in general is a project in the voluntary sector—an experiment in the use of nonprofessional college graduates being carried out by the Spence-Chapin Adoption Service in New York.[4]

Most of the informal efforts being made in public agencies toward differential use of child welfare manpower are based on the traditional model of a primary casework relationship between one worker and the family. The differentiation comes in the assignment of the case according to the degree of complexity of the client's needs. The "easier" cases go to the subprofessional worker; or, the apparently long-term cases and the apparently short-term cases are differentially assigned.

Both smaller caseloads and differentiation of cases by level of difficulty were used in the project by Weed and Denham,[5] in which 50 preprofessional workers from 18 child placement agencies in New York City were given special training to carry placement cases.

Since both difficulty and length of service are imprecise criteria at the time of intake, and there are apt to be many changes in the staff and in the client's situation in the course of service, the tendency may be for everyone to end up doing the same thing.

A Demonstration Project

A 5-year demonstration project just getting under way at the Illinois Department of Children and Family Services is taking a different approach. The goal is to extend the use of professional skill with teams made up of a professional worker and several subprofessional workers, with a differentiation of responsibilities for the same cases according to the abilities of each. The major objective is to demonstrate the feasibility of the team approach. Because this is a departure from typical procedures in public child welfare programs, the rationale and goals will be described here in further detail.

Our greatest concerns in planning the Illinois project have been goal-setting and devising built-in methods of evaluation. Scientific research on a problem with so many uncontrollable variables is difficult to design. Yet without careful evaluation a demonstration project may result in an automatic "A" for effort without any real assurance that the method demonstrated represents any gain over previous approaches. We expect such a team approach to extend the use of professional skill and knowledge so that staff can be deployed to provide quality service and more adequate coverage. At the same time, we hope that the project will help increase staff morale and interest.

Goals and Assumptions

We expect to concentrate on two processes—*intake* and *foster family care*. A concentration on intake is important for securing adequate data on the initial aspects of the cases and the decision-making that goes into the diagnosis of the problem.

Intake is also of interest because of the considerable disagreement today concerning the training needed by intake staff. The problem is complicated by differences in definition. If intake is seen as screening before case assignment, the knowledge required may be different from that needed for carrying out a longer process of diagnosis and development of a tentative plan to meet the child's needs.

One of the basic questions we hope to answer is the degree to which the conclusions reached at intake are validated later. If diagnosis at intake is usually modified substantially as the child is served, less effort at intake might be directed toward a detailed formulation and an assignment made earlier to the regular casework staff.

A lengthy intake-diagnosis process, preceding acceptance of the family for service, may have serious negative effects on client motivation. Since the Department's various units operate with several different philosophies and patterns for intake, the project will provide some basis for comparison.

To keep the project of manageable size, detailed analysis will be limited to foster family care. Comparisons between project cases and regular cases will be made in terms of length of placement and the proportion of replacements in each group, as well as in the development of special behavior problems. Attitudes toward agency service by both foster and

natural parents will be determined by independent interviewers.

The project is based on the theory that foster care can be profitably studied as a decision-making process involving various functions and levels of complexity. A listing of the decision-making abilities of professional workers and subprofessionals with a bachelor's degree indicates few differences in the characteristics of the two groups of workers. Persons in either category may be observant, logical, and adept in applying a sound method to the problems under consideration, within their respective areas of responsibility. The difference between the two groups is that the education and background of the worker who is professionally trained allow him to understand more fully the real nature of the problems involved. From this, it should be possible to differentiate functions so that each category of workers performs effectively within clearly defined ranges of decision-making responsibility.

In the project, it is assumed that operations consisting of tasks that can be set forth fully in a manual involve little need for professional skill. From guidelines provided, the subprofessional member of the team can make the necessary decisions.

Some questions demanding decisions are in a middle range of complexity, and all their elements cannot be anticipated by manual material. In such instances, the subprofessional can call on the professional worker for validation of his decision, as is now done in the process of supervision.

Finally, some decisions in the foster care process require direct involvement of the professional worker because of their gravity, complexity, or uniqueness.

Foster Care Teams

While the size and organization of child welfare teams might vary widely, the foster care teams in Illinois are to be made up of a professional worker and several nonprofessionally trained college graduates. All will have had full orientation and inservice training concerning foster family care. The professional worker will have a master's degree in social work and a minimum of 6 months' experience in the agency. Case assignments will come to him. Typically, he will have firsthand contact with the client families for initial planning and for special problems or crises. The family will expect service both from him and from the junior worker, but will not ordinarily receive information on the rationale for the workers' differential responsibilities.

Conferences between worker and supervisor will largely be replaced by the relationship between the junior worker and the professional worker. The supervisor will be responsible for case assignments to the team in order to keep the work load of the agency balanced. He will serve on request as consultant on the case, but he is required to be involved in only one decision—termination of service. The supervisor is also expected to carry staff training responsibilities.

Modifications in recording are contemplated, but recording requires no more time than workers now spend and possibly less. Each team will have a clerk assigned to it. Plans are to determine which of the functions carried on by the child welfare workers can be reassigned to a clerical worker.

Through the foster care team, we hope to give to the professional worker higher levels of responsibility; to the subprofessional, specific inservice training and experience; and to both, the stimulation of team participation. At the same time, we expect to have a method for extending professional skill to deal effectively with crises and other major problems.

We believe that the flexibility provided by this team approach in child welfare effectively takes into account the two yardsticks recommended by the NASW commission on practice for determining the division of responsibility among social agency personnel—the degree of the client's vulnerability to stress and the degree of the worker's ability to function autonomously.

This team approach to staff use is conservative in that it recognizes the importance of the relationships between client and agency staff. The fact that it enlarges the scope of the relationship with a family to involve more than one worker may result in clients identifying more with the agency than with an individual worker. However, even in traditional ways of operating, when longer term service is provided, the passing parade of workers may make the agency rather than any one individual the stable element in the relationship.

Other Experiments Needed

Many more innovations and systematic research-demonstrations are needed to test out both present assumptions and new methods of staff use, in order to find better ways to deploy professional manpower, to spread scarce skills, and to develop more effective means of training.

We need more radical projects that may involve drastic redesigning of ways of providing service. At the 1965 meetings of the Council on Social Work Edu-

cation, Samuel Mencher of the University of Pittsburgh proposed a public health model [6] and Arthur W. Blum of Western Reserve University suggested an extension of the institutional treatment model.[7]

The public health model, Mencher said—

> draws upon the changing nature of environmental demand for its identity. Social need and the broad field of social welfare rather than established skills would shape the course of professional function for social work. The profession here is not so much concerned with cutting out a unique place for its own practice as finding answers to the ever-changing complexity of social problems. The foothold on traditional professionalism becomes more shaky as we no longer have a well-circumscribed field of operation. The professional is not so much a primary force in his own right as the agent of individuals, groups, and communities in . . . helping [to] bring the vast technical skills and resources of society in line with the welfare of all. . . .

Blum emphasizes the need for a worker—

> who has the major responsibility for the case but whose job includes the coordination and utilization of a team of specialists. . . .
>
> This differentiation of tasks and use of a team approach would also provide us the opportunity to build upon the strengths which the worker brings to the agency and make it possible to compensate for weaknesses. One worker would not be expected to be all things to all people.
>
> A multifunctional approach of this kind offers other advantages as well. We would . . . face the necessity of creating a series of job categories which are essential to the services we offer. Jobs could be created which are "respectable," which do not require graduate training, which are not designed specifically as recruitment devices for schools of social work, and which permit promotion and career aspirations to be fulfilled. Employment could begin within the categories which demand routine services or which are dependent primarily on what the worker brings with him to the job. The worker could progressively advance to jobs whose tasks require additional skills and knowledge. The position of professional social worker could be differentiated in terms of the functions he would perform in this interdependent staff network which are related to and dependent upon his professional education. . . .

Blum also proposes "crises teams" on 24-hour call. These teams would have special skills. Workers would not have to drop everything to handle emergencies and the client would receive assistance from an agency designed to help him.

Public child welfare programs have been fortunate in having professional social workers in leadership positions. This has made possible the development of high-quality services. However, it has also made for too conservative an attitude toward experimentation in the use of manpower.

There is room for testing out many new approaches. To meet the demands for service, we need a sense of adventure and a willingness to communicate our plans as well as our results.

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[1] NASW Subcommittee on Utilization of Personnel: Commission on practice utilization of personnel in social work—those with full professional education and those without. National Association of Social Workers, New York. February 1962.

[2] French, David G.: Needed research on social work manpower (report to the Task Force on Social Work Education and Manpower). U.S. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services. 1964.

[3] Costin, Lela B.; Gruener, Jennette R.: A project for training child welfare personnel. *Child Welfare*, April 1964.

[4] Montgomery, Helen B.: Differential utilization of social work personnel. *Children*, May–June 1964.

[5] Weed, Vene; Denham, William H.: Toward more effective use of the nonprofessional worker: a recent experiment. *Social Work*, October 1961.

[6] Mencher, Samuel: The evolving professional function. Paper delivered at the 1965 Conference of the Council on Social Work Education, Denver. January 1965.

[7] Blum, Arthur: Manpower utilization—wishful thinking unfulfilled. Paper delivered at the 1965 Conference of the Council on Social Work Education, Denver. January 1965.

It is never easy to be poor. Hunger, cold, ugliness, thwarted ambition, are always hard but they are harder when one lives with them in the midst of all the goods and all the opportunities, as youth does today. "You can fight your way up," they are told. Certainly there are people, young and old, who have done this and still do it. But we must finally accept the knowledge we have gained in the last decades that man is neither a product of environment nor of his innate heritage, nor of his free will alone. What he is and becomes grows out of a combination of these three factors.

Gisela Konopka, of the University of Minnesota School of Social Work, to the 1965 annual meeting of the American Orthopsychiatric Association.

IMPROVING COORDINATION OF WELFARE AND MEDICAL SERVICES

MARGARET A. DENNIS

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Welfare-Medical Care Project, The New York Hospital, New York City

SINCE THE 1930's, some kind of medical care has been provided for recipients of public assistance. Only recently, however, has attention been paid to the quality of this medical care—and to the kind of medical care facilities which might best serve these recipients. Experimental research is under way in a number of places to discover what kind of care is feasible and the extent to which it can be continuous or comprehensive.

The New York Hospital Welfare-Medical Care Project is one such experiment. Its purposes are to determine the feasibility of giving public assistance recipients complete medical care under the auspices of a voluntary hospital and to study the cost, utilization of medical services, and quality of this care.

Because of the experimental nature of our project, a random selection of public assistance recipients, irrespective of health status, was made. As a result, the social problems encountered in the project covered a wide range of psychosocial disability not primarily stemming from serious illness and physical disability. When such a demonstration takes place in a hospital in which social work is established, social workers are called upon not only to serve clients but also to look for ways to improve working relationships with the local welfare organization and new ways to coordinate services. Our project experience has shown that our usual methods of collaboration with the New York City Department of Welfare are often inadequate, particularly when clients' problems are complex and when different disciplines and institutional differences are involved.

The New York Hospital-Cornell Medical Center, where the project is located, is a large voluntary teaching hospital. The welfare district served by the project takes in two welfare centers—about 100 city blocks on the East Side of Manhattan. The project patients are clustered at either end of this racially mixed area. Puerto Ricans, comprising more than half of the total number of people in the project, live mostly in the upper end of the district, known as Spanish Harlem.

Between July 1, 1961, and June 30, 1962, 1,028 cases were selected randomly as they became eligible for public assistance, then assigned to the project for medical supervision. By and large, our project patients have required ambulatory medical care.

The project clinic staff works within the hospital's general medical clinic and the pediatric clinic. Our project group consists of a full-time director and an associate, both physicians; internists; pediatricians; a part-time psychiatrist; a nurse; and a social work coordinator.

Based on a paper presented at the 1964 forum of the National Conference on Social Welfare.

The pattern of medical care provided by the hospital's comprehensive care program has been used. Clinic care is given by appointment, or without appointment when patients "walk in." A bed is available in the hospital when necessary, as is the hospital's home care program.

Added features are the following: Individuals and families are entitled to medical care after clinic hours and have access to a project physician by telephone. House calls are made when necessary or when the emergency room is used. Psychiatric consultation for patients has been available from the outset. Care in nursing homes is supervised by a project physician. As a medical care facility of the Department of Welfare, the project accepts responsibility for medical evaluations of pending applications for the aid to the permanently and totally disabled (APTD) program. Work status is evaluated but always in conjunction with continued medical care.

Casework is provided project patients on referral within the existing structure of the Social Service Department. No social workers have been added except the social service coordinator. The bulk of work has fallen to the social workers attached to the general medical clinic and to the pediatrics division, where our project physicians are located.

Problems Encountered

Since our hospital provides medical care and has a Social Service Department, it responds to the needs of the Department of Welfare in two traditional ways. The first is to provide medical information and recommendations. The second is to provide social work within the hospital through the Social Service Department, which is prepared to work cooperatively with the Department of Welfare.

Of the 586 cases in the project for medical care in the past 2 years, approximately two-thirds were referred to the Social Service Department by project physicians. In order of frequency, the types of problems encountered by our social workers during the first year were in the following areas: family relationships, child behavior and child care, personal adjustment; employment and work rehabilitation; facilitation of medical and psychiatric care; financial problems and housing. Chronically dependent single adults and families with a multiplicity of problems became "our clients" also.

We decided to use the project client group to take a look at what the Department of Welfare asked of the hospital and what happened to the medical information and recommendations sent to it. For 18 months, all letters from the two welfare centers concerned were screened by the social service coordinator, a physician, and a psychiatrist. We found that medical opinions in relation to employability and work rehabilitation were requested. Psychiatric examinations were requested to determine individual competence to cope with daily living or with welfare requirements; to determine competence of parents to give adequate care to children; and to determine the nature of childhood behavior disorders and to recommend treatment.

The Need for Coordination

Two of our cases show the difference that coordination can make. In the first, no casework assessment was made at the hospital:

Mr. D is a 53-year-old single man, who speaks practically no English and has no relatives in this country. He has no work skills and has always done odd jobs, mostly as a dishwasher. He developed a hernia at work and a compensation claim was submitted. He has since refused to have this hernia repaired because litigation is in process.

Nobody at the hospital could find out very much about this man who kept insisting that he was disabled. Despite his hernia, it was thought that there were no reasonable grounds for his not seeking employment. But the Employment and Rehabilitation Division of the Department of Welfare had already tried to find employment for him and failed. Our psychiatrist examined him, and in June 1963 we sent the following report to the welfare center:

"Mr. D is a short, lame man who has no serious organic problem, but ever since a foot injury as a child has considered himself disabled. He has a limited intellectual capacity and is not a candidate for training. However, he keeps under regular medical superivision by appointment and occasionally 'walks in.' His headaches and abdominal pain are treated symptomatically. Should there be evidence from your visits, or from people in the community, that he is less and less able to manage, please let us know."

In November 1963, a new public assistance worker was assigned at the welfare center. He visited Mr. D and put a note under his door to ask him to go to the hospital for an employment physical examination. The patient came running to the project desk, having developed several new psychophysiological symptoms on the way!

Mr. D, like many a Department of Welfare client with a chronically unresolved problem, was caught up in an unnecessary merry-go-round between the Department of Welfare and the hospital. This kind of unresolved issue which drags on for months and even years can undermine clients with stronger egos than Mr. D's and can contribute to an irreversible state of financial dependency.

What, then, does the Department of Welfare expect of the hospital? Practically nothing in the way of cooperative social work, yet two-thirds of the cases

about which the welfare centers had inquired were known to the hospital social workers. Despite the usual exchanges between the hospital social workers and the staff at the welfare centers, it was obvious that the staff of the centers still looked upon us as dispensers of medical and psychiatric findings. They did not look upon us as co-workers interested in improving the lot of the clients to whom we had a joint commitment.

The following is an illustration of the way in which an appropriately coordinated effort between the hospital caseworker and the welfare center staff can benefit a client and his family. This was a project case, but there were in it no departures from normal hospital casework practice:

Mr. J, a 46-year-old married father of five children, was discharged from a State hospital in 1958 with a diagnosis of chronic paranoid schizophrenia. He was formerly employed as a construction worker, and had been imprisoned at Sing Sing. He had not been employed since 1952. In his mind, his "nervous breakdown" occurred because the Department of Welfare continued to pressure him to return to work. Along with this mental illness, his family situation has been tense and ungratifying.

When Mr. J asked the physician to permit him to return to work, a referral to the hospital social worker was made for evaluation of employment and family problems. Work was contraindicated, but stabilization of the patient and family was urgent. With the help of the hospital social worker, the welfare center has adapted its service to meet the needs of the whole family. The patient, still subject to unpredictable recurrent emotional crises, seeks counsel from the caseworker and the physician. He has stayed out of the hospital and has shown some signs of improvement. He may eventually be able to work.

In this case, the patient was helped by a coordinated approach from medicine, psychiatry, and social work. The hospital contributed an assessment of the total family, ascertained the sources of stress for the patient, and set reasonable goals which were interpreted to the welfare center. It was then possible to coordinate services to the family as a whole.

Some Handicaps

More often than not, however, individuals—and, particularly, families—who came under project care have had complex problems in diagnosis and treatment which defied our usual methods of providing coordinated care within the hospital, to say nothing of coordination with the Department of Welfare. To some extent, we were working under what might be called an institutional handicap in attempting to provide family care.

Even when comprehensive medical care is practiced in hospitals, it is only at best family oriented. The hospital is "wonderfully one times one," in that the patient rather than the family is the unit of reference. There may be a unit record, seldom a family record. We work in departments or on specific services with policies that often split care. We have unwritten codes which govern how far the institution will extend itself to fulfill its own purpose or serve the community.

The welfare centers may not always reflect the high degree of commitment of the city's executive branch. They are often ruled by categorical requirements, rather than by the needs of individuals or families. In New York City, a specialized medical-social work office exists in each center; it serves as liaison with hospitals and keeps an administrative eye on all medical care services. This kind of administrative separation of medical care from the work units has seriously reduced the investigator's understanding of health problems, has lessened his initiative in working cooperatively with hospitals, and has seriously reduced the effectiveness of the medical social workers as case consultants.

Within the project over the past few years, in an attempt to weld ourselves into a closely coordinated, responsible team, we have tried variations of established methods used in medicine and social work. In our project clinical conferences, we have learned how important it is to have the full benefit of the findings and observations of each discipline reported and then reassembled in group discussions where opinions can be aired. These discussions have aided us in providing coordinated medical care and social work for selected problem families. They have also brought to light new issues on which we have had to take a stand with our Department of Welfare.

In approximately 60 percent of the cases known to the hospital social workers during these 3 years, there has been cooperative work with the Department of Welfare and other social agencies. Significantly enough, it has been the project which, in all but two instances, has called interagency conferences to try to bring order out of chaos or find some means of preventing further breakdowns.

The following case, which gave rise to one of these interagency conferences, was called to discuss coordination of services to families in which parents were not able to give adequate care to children:

The W family consists of a retarded mother, a near-psychotic father, and three children under school age. The mother's distracted inability to manage simple housework, or provide minimal physical care for the children, soon became apparent. Because she wanted it and was nearing the end of her child-

bearing cycle, a tubal ligation was recommended. The slow process of explanation to Mrs. W and her husband was dealt with painstakingly by the hospital social worker and a project physician. To permit Mrs. W to come in to the hospital for this operation, they strongly recommended temporary placement of the children, convinced that the father would not tolerate a homemaker. The welfare center, in full agreement, requested temporary placement from the Child Welfare Division of the Department of Welfare. An admission date was set but postponed because the Child Welfare Division would not accept the hospital's opinion and recommendations.

After one interview, the worker from the Child Welfare Division announced that the father did not want placement of the children. The case was then rerouted to the welfare center for rerouting to the Special Services Division to request a homemaker. A representative of this division went in and was appalled at the state of the home, which had not even the minimum furnishings or equipment. Although some doubts were expressed, it was decided, after a big shopping spree, to send in a homemaker.

On the day of admission, the hospital social worker received a frantic telephone call from Mrs. W to come and straighten things out. That morning, the public assistance worker had arrived; then the worker from the Bureau of Child Welfare, followed by a homemaker and her supervisor from the Bureau of Special Services; and finally a Peace Corps volunteer. Mr. W loudly protested and refused to permit the homemaker to stay. When the hospital social worker arrived, they were all at a noisy impasse. On this interagency home visit, the only person who accomplished anything was the Peace Corps volunteer, who fed and changed the baby.

To describe in detail the subsequent events and continued difficulties with this case would take too much space. However, it illustrates how excessively complex family problems can be further complicated by lack of interagency coordination. While the lack of coordinated social work in this case may border on the absurd, it illustrates dramatically how much we are caught up in interagency autonomy, and how impotent this makes us when we try to provide services to disorganized people.

Reconciling Differences

After such experiences, we became convinced that the project must find a way, with the Department of Welfare, to examine and reconcile our differences in practice, policy, and commitment.

The random sample of public assistance recipients in the project provided a resource of identifiable material. In the third clinical year, we launched at the welfare centers what we call, for want of a simpler title, "teaching-consultative conferences." While the burden of teaching and the initiative came from the project staff, we had much to learn about each other. The purpose of the conferences was to improve services to clients, and to uncover agency policies, practices, and prejudices which impinged upon services to clients and interfered with coordinated social work and medical care. These conferences were not used as substitutes for interagency conferences involving other agencies than the welfare department.

While the conference technique has often been used in the past, our experimental conferences have two features which distinguish them from the regular interagency conferences. First, they represent a continuous medical and social work effort: the social service coordinator and the same project physician constitute the hospital team which meets regularly with the staff of the welfare centers. The cases are presented and discussed by the physician and coordinator. Other hospital staff members are invited when they have a contribution to make. The second feature is that the welfare centers' case supervisors, rather than the medical social worker, cooperate in the choice and preparation of cases. The workers and unit supervisors prepare and present the cases. The medical social worker attends conferences, but, for reasons already stated, is not directly involved. Discussion is as free as we can make it at this early stage. Two—at the most three—cases have been presented at each session, with time left for followup. We are now working on an outline for presentation which is based upon the forms used by the welfare centers to evaluate service needs.

Month by month, we have taken a look at these unresolved problems: how to facilitate medical and psychiatric care; how to assess medical and psychosocial disability and set reasonable expectations for the chronically unemployed client; how to assess family problems, and what to do about inadequate parents; how to work together in the evaluation and treatment of behavior disorders in children.

Let us now return briefly to Mr. D, whom we left in a state of anxiety at being asked to prove himself unemployable. He was chosen for one of our experimental conferences.

When we sat down together to discuss Mr. D at the welfare center, we found that neither the public assistance worker nor his unit supervisor had made use of our letter, which had been tucked away in the voluminous correspondence file. The public assistance worker believed that Mr. D's disability was "all in his mind," but had no idea how to get it out. He also felt strongly that this man should work. We learned from him that Mr. D had now settled down in his neighborhood (having found a motherly Italian landlady) and appeared content.

What had we learned so far? Even when the hospital provides medical and psychiatric informa-

tion, it may not always be used to good advantage by the welfare center. In this case the center's orientation was on reclassification, rather than on service to the client. When a new public assistance worker was assigned, Mr. D was treated as a new case whose eligibility was still undetermined. The written invitation to the welfare center to keep in touch with the project went unheeded.

However, when we talked it over, the welfare staff began to understand Mr. D's limitations. They gave up the immediate goal of reemployment. The worker was relieved and reassured about his commitment to the client and his responsibility to the agency. The patient has, since then, used the hospital less for anxiety symptoms. The welfare center has not requested further physical examinations.

Our experience to date has shown that improvement in cooperative work with the Department of Welfare can only be made by recognizing that the invisible curtain which sometimes exists between us is hung in the hospital as well as in the Department of Welfare. Misconceptions and biases about medical care and social work exist on both sides.

The assessment of our experiment to coordinate care and improve working relationships between the hospital and welfare centers is still in process. We are encouraged, however, by the fact that the welfare department sees this experiment as a useful teaching-consultation device. Next year, we hope to incorporate these conferences into the training program of the welfare centers.

Our casework and project experience with this random sample of public assistance recipients strongly suggests that hospital social workers need to reexamine certain aspects of their practice.

First of all, it raises questions about our established system of referrals. Examination must be made of new sources of casefinding which do not depend wholly upon referrals from physicians. The characteristics of the clients, their ways of coping with stress, and their patterns of response to all disciplines within the hospital will bear careful scrutiny; and so will our patterns of response to them.

We must find ways to categorize the kinds of social dysfunctioning, with or without the presence of serious medical and psychiatric illness, in which we are prepared to intervene. It is also essential to delineate those special problems within the scope of our present practice which stem directly from a breakdown in relationships, maintenance, or services between the client and the Department of Welfare. Such problems may well be handled at a service level by nonprofessional staff, and at an administrative level by those who are in a position to change policy or procedures.

A sick child looks to hospital staff members for affection. Assuring appropriate care for sick children at all times requires effective coordination of public health and welfare services.

What has also emerged from our experience is proof that our traditional methods of casework intervention are often inadequate. While we are used to working with crises in hospitals, we cannot always find ways to release the energies of public assistance recipients to work on their problems, chronic or critical. Yet we have been effective with some very complicated cases and hard-to-reach clients. I think we would do well to be courageous and look hard at our results, to see if we can find out why we succeed and why we fail. In order to serve more people more effectively, we need to set priorities and learn how to use our skills economically. This calls for experimentation in new social work techniques, such as group treatment or social action groups among clients. We must be prepared to take a stand on current issues which, affecting public assistance recipients and their impoverished neighbors, cry out for social action.

The task is enormous. We cannot afford to close our eyes to the difficulties involved in coordinating social work and medical care for recipients of public assistance. But we need not work at cross purposes if we are prepared to join together to see what is good and effective—and what needs to be improved—to strengthen individuals and families.

THE HOSPITAL THROUGH A CHILD'S EYES

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THE CHILD who is hospitalized enters a strange, sometimes terrifying world. He is under the stress of illness, separation from his parents, and the mystery of a vast, complex, and unknown setting. The experience can be traumatic. Often it produces behavior unusual in the child. The health professions concerned with helping him during this period of crisis need to know more about what he is feeling and thinking: Does he know why he is there, what will happen to him, what is expected of him? Mothers taking leave of their children at the hospital often demand or beseech them to "be a good boy (or girl)." What does good behavior in the hospital mean to a child?

In an effort to learn more about these young patients, their view of the hospital world, and how they learn to function in it, we have interviewed 40 hospitalized children. The children—20 boys and 20 girls—were patients in 2 hospitals in the Boston area: a large general hospital and a smaller hospital for children. Those in the large general hospital had been admitted to the pediatric unit through the outpatient clinic. Those in the children's hospital were under the care of private physicians.

The head nurses helped in selecting the children for the interviews. Physical condition and age were the two important criteria. No seriously ill children were included. All the children were between the ages of 6 and 9 (mean age, 7.6 years) and thus were in what the developmental literature calls the latency period—a period in which the child characteristically is willing to apply himself to the tasks at hand.[1]

All but five of the interviews were conducted during the child's first week in the hospital. Thirty of the children had had or were facing surgery; 29 had had previous hospitalizations. All but two of the children had attended school before coming to the hospital.

The Interviews

At first we established rapport with the children through a small group play session. Immediately after this, the individual interviews began, and, as far as possible, only the interviewer and the child were present. As interviewers, we wore street clothes with smocks rather than nurses' uniforms, so that the children would not confuse us with the nurses providing them with treatment. Because we believe that children may have trouble talking about values in behavior on direct questioning, we used a pictorial approach to elicit feelings and beliefs. The drawings showed:

1. A child approaching the steps of a house, where

a smiling woman with a gesture of welcome is opening the door.

2. A child and a woman talking inside the home.

3. A child and a woman approaching a hospital.

4. A child talking to a nurse in the hospital ward.

In each picture shown to a particular child, the child portrayed was of the same sex as the interviewee. The interviewer began by saying: "I have some pictures here and I would like you to tell me what you think is happening to the little boy (or girl)."

During the discussion of the pictures, the children, with a few exceptions, became relaxed and interested. Then the interviewer went on to ask the direct questions:

• Why do children go to the hospital?

"Because they are sick" was the most frequent answer (19 children). Specific conditions were named by 15 children—broken leg (6), pneumonia (4), cuts (2)—often the conditions for which they themselves had been hospitalized.

"To get better," said 12 children.

"To get fixed up," said three.

Many of the children gave more than one answer to this and the other questions.

To get more information on how the children interpret the intent of hospitalization or hospital personnel, the answers were labeled "positive" or "negative" in intent. Included in the "positive" reasons were such answers as "to get better," "to get fixed up," "to get taken care of," "so the doctor will know what is wrong and then help you."

Fifteen of the private patients gave positive reasons for hospitalization; only two clinic patients did so. Age may have been a determining factor here, since the private patients were, on the whole, older than the clinic patients.

The 9-year-olds were most generally positive (7 of 12); younger children, less so—age 7 (4 of 7); age 8 (only 1 of 10); age 6 (3 of 11).

• What happens to a child in the hospital?

"You get the needles," said 23 children.

Operations were mentioned by 16 children, medications by 10, play by 6, and temperature taking by 5. Also mentioned were casts, polio shots, polio drinks, blood pressure, and anesthesia. Girls more frequently mentioned examinations and medicines than boys; boys, more often operations. Whether or not the child had been previously hospitalized did not appear to influence the responses.

• What does mother mean when she tells you at home to "be good"?

"To help her and do what she says," 25 children said. The majority of these (16) were girls. More specific answers were: "to run errands," 11 children; "to do homework," 10; "to play," 8; "to be polite," 8.

• What does the nurse mean when she says the child is a good boy or a good girl?

"To do what the nurse says," said 21 children. More than twice as many private patients gave this answer as clinic patients.

"To go to bed," "lie down," or "go to sleep," answered 21 children.

"You don't cry," said 14; "be quiet," 11; "take medicine," 7; "eat everything," 7. Other answers: "You help other children"; "play"; "be polite"; "don't play rough." Some individual comments:

"You don't scream when you get the needle or when they take your blood. When they take your temperature, you don't scream." (Six-year-old clinic patient.)

"You don't give her any trouble when she goes for a needle. You let her do it without crying. You go to bed when you are told and you eat when you are told." (Nine-year-old clinic patient.)

"You listen to her and do what she says. You take pills, go to bed and don't be noisy." (Eight-year-old clinic patient.)

"You obey and try to get better." (Eight-year-old clinic patient.)

"You don't bother the nurse. Don't interrupt her." (Nine-year-old private patient.)

"You keep out of the nurses' way." (Nine-year-old private patient.)

• How did you find out how a good boy or good girl should act in the hospital?

"I just knew" was the most frequent answer (14 children), especially among private patients (11) and boys (10).

"Mother told me" came next in frequency, and came mostly from girls (11).

"The nurse" was given as the source of information by eight children; both mother and father by six. Five of the younger clinic children said they did not know how they found out. Some comments:

"I know because I'm smart." (Eight-year-old clinic patient.)

"From my mom. She yells at us and tells us to be good." (Six-year-old clinic patient.)

"When you are a baby you can start to learn from your mother and father." (Seven-year-old private patient.)

"When a lot of little kids screamed, the nurse said they are

not good, so I learned that way." (Eight-year-old private patient.)

"Just know. I was always good when I went to the hospital, so they wouldn't get mad at me." (Nine-year-old private patient.)

"Your mother and father teach you manners and how to act." (Eight-year-old private patient.)

At the conclusion of each interview, a notation was made as to how much at ease and how comfortable the child had appeared when reacting to the pictures and answering the questions. Of the total, only seven children (four, age 6; one, age 8; and two, age 9) did not respond freely. Six of these were in the clinic group. The children in the private setting, although responsive, seemed more anxious to please and to give the "right" answers. They seemed more prone than the children from the clinic to look for clues in the behavior of the interviewer which would indicate approval or disapproval. For the most part, the children did not seem to mind having their remarks recorded; some of the 8- and 9-year-olds seemed pleased.

Some Implications

These responses indicate that parental admonitions to "be good" in the hospital seemed to have definite meaning for the children we interviewed. They saw their roles this way: to conform in behavior, to be quiet, not to resist treatment, to keep out of the way of nurses and doctors. As one 8-year-old said: "You let them do what they want to you. You do as the doctors and nurses say."

In general, the children said they had learned mostly from their parents what behavior was expected of them. They also reported learning by observing the nurse-patient interaction within the pediatric unit. Few mentioned the influence of their peers. Most of the children gave realistic reasons for children's being hospitalized. The older the children, the more likely they were to give a more positive interpretation of the intent of the hospital personnel. The 6-year-olds had the most negative attitudes, as would be expected from studies indicating that young children view hospital procedures as intrusive.[1] More than half the children associated the hospital with "needles"; age did not influence this reaction.

Thus it seems that a child in the latency period views the hospital as a place where children go because they are sick and want to get better. In the hospital, children receive passively and without question the needles, operations, examinations, and medication that nurses and doctors deem best for them. The whole situation seems to resolve itself into one of passive conformity, in which there is little if any possibility for the patient to participate actively within the environment. The child senses that his fate has been predetermined by others, and that he is being acted upon rather than participating as an actor.

There seems to be a marked similarity in the way children and adults see acceptable behavior in a hospital setting. Adults have described good behavior as being submissive, noncomplaining, and following the rules and orders.[2] The children we interviewed apparently learned early the value of conformity in the hospital. At their stage in life, they have undoubtedly also been receiving from adults at home and in school, considerable pressure to conform. Thus, developmentally, a tendency on their part toward conformity could be expected.

The question arises, however, as to how much pressure toward conformity may be necessary in a hospital pediatric unit and how much is therapeutic or the opposite. One wonders how much conformity children of this age can tolerate without having it seriously affect their emotional growth. If there is a danger point in conformity, then the longer the interval of hospitalization, the greater the hazard to normal growth and development.

The school has built-in outlets for the child's need for motor and vocal expression. Afterschool activities, the daily play period, and the annual vacation furnish further outlets for such expression. Many pediatric units, however, are only beginning to provide play programs and other planned recreation.

However, beyond the need for outlets for expression, the child of latency age needs to win recognition by being productive. Could the hospitalized child's desire to please be used in a more constructive manner? Is he ready to learn more about health and health practices during his stay? No child mentioned "learning" as "good behavior" in the hospital. Hospital personnel do not seem to have capitalized on the desire of children in their care to learn to do things well. Nor have they exploited the willingness of the child of latency age to practice in order to become proficient. Surely these are ways in which the hospitalized child who is not seriously ill might be helped to function more productively.

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[1] Erikson, Erik: Childhood and society. W. W. Norton & Co., New York. 1950.

[2] Coser, Rose Laub: A home away from home. *Social Problems*, July 1956.

Some reasons for a liberal screening policy in . . .

A PRESCHOOL PROGRAM FOR CHILDREN WITH CEREBRAL PALSY

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WHEN A CHILD with cerebral palsy approaches nursery school or kindergarten age, the question which confronts parents, doctors, school officials, and everyone concerned is: Will this child ever be eligible for schooling? The eligibility of the child, in most cases, depends on several factors: achievement on a standard intelligence test, degree of physical involvement, ability to communicate or take care of his own toileting needs, and chronological age.

The entrance requirements placed on disabled children by many schools or kindergartens are much greater than those for normal children. Children who show no obvious disabilities need only to show proof of age to enter school, whereas children with known disabilities often have to meet rigid requirements.

Children whose physical maturation is retarded develop more slowly than others in such areas as ambulation and speech. Such children are known to perform poorly in tests in their preschool and early grade school years. Any child whose backlog of experiences and information deviates greatly from the normal child's will perform below par on a test which is designed for children who have had "normal" experiences for their age.

One should not expect a child who perceives the world about him differently than others do to gain the same experiences and information from his environment and react to it in the same way. Because some authorities do expect this, some children with cerebral palsy are excluded from schooling without being given a trial.

To give such children a chance to learn, the Cooperative Pre-School Center of the Cerebral Palsy Association of Western New York, Inc., considers for entrance any child between the chronological ages of 3 and 7 who has been diagnosed medically as having cerebral palsy.

All children are interviewed by the principal before entrance, but only a few conditions may cause a child to be excluded. This happens when:

- The child appears to have no response to his surroundings. (Responses need be only with his eyes.)
- The child is unable to move about on the floor in any manner.
- The child is very immature. Exclusion may in this instance be only until he is a year older.
- The school has reached capacity enrollment. In such instances the child is placed on a waiting list.

Any child who is not accepted by the nursery school can enter the day-care program of the Cerebral Palsy

769-106—65——3

Association of Western New York when he is 5 years old. This is purely a recreational program.

Our liberal screening policy is based on the realization that several factors can hinder a child's development. These are lack of proper stimulation, unfortunate parental attitudes, mishandling of the child, and lack of knowledge about cerebral palsy on the part of parents and family members.

We have found that many children can exceed what they are initially thought capable of doing, when they are taken out of their familiar surroundings and placed in a nursery school where they experience understanding and patience, are guided in play, and receive training in visual, tactual, and auditory perception.

All children who are admitted to the Cooperative Pre-School Center are on a trial period for 5 months. The child is allowed to remain longer if, by that time, he shows progress in any one of the following areas:

- **Physical:** (a) self-care; (b) ambulation; (c) manipulation; (d) toileting; (e) feeding.

- **Social:** (a) group participation; (b) ability to get along with others; (c) sharing.

- **Emotional:** (a) self-discipline; (b) self-control (control of temper tantrums); (c) ability to take changes; (d) ability to respond to criticism and suggestions; (e) self-confidence.

- **Educational:** (a) visual and auditory perception; (b) attention span; (c) varied experiences and types of learning—art, music, and free and purposeful play; (d) communication.

Over the years, we have found that toilet training, awareness to surroundings, ability to handle materials, and means of communication can be improved through guided experiences.

Toilet Training

There are many schools where children are excluded if they are unable to communicate their need to go to the toilet. The reason for making toilet training a prerequisite for schooling is based on the fact that most children attain toilet training by the time they are 2 to 2½ years of age. "If a child is not toilet trained," it is argued, "he has not reached a mental age which would indicate readiness for preschool." [1]

The preschool staff of the Cerebral Palsy Association believes that this concept is not applicable to all children with cerebral palsy. Some children with this affliction have difficulty controlling rectum and sphincter muscles. Moreover, some children are unable to sit on a toilet seat, a fact which in itself could delay toilet training. To exclude a child for either of these reasons would be a great injustice to him.

True, some children not emotionally or intellectually ready for toilet training are likely to achieve it at a later age. However, even these children in many cases can profit from other areas of training offered by the school.

The results of a survey of children who attended our preschool program between 1955 and 1960 indicate that we have had reasonable success in toilet training. Part of this success may be due to the fact that many children have less difficulty learning in a group situation than in individual training. But whatever the reason, the results of the survey showed that, of 81 children who either were not toilet trained (77) or about whose toilet training there was some uncertainty (4) when they were admitted to the nursery school, 56 became toilet trained before they left the school.

Intelligence

Besides toilet training, achievement on a standard intelligence test is used in some nursery schools as an entrance requirement. The accuracy of these tests depends on many factors: the rapport between the tester and child; how the child feels; the child's attitude at the time of the test; and the child's ability to respond in an acceptable way. The last factor can be crucial, since many children with cerebral palsy have trouble communicating. In some cases the child's speech may be so unintelligible and the physical involvement so great that testing does not give a true picture of his intelligence. Factors such as these can make a test score lower, indicating a lower potential than the child actually has.

Persons working with children with cerebal palsy soon learn that these children need help in acquiring many basic experiences that normal children acquire on their own. For several reasons a cerebral palsied child's learning at home may be hindered. This may be due to the parents' allowing or even encouraging their child to become dependent because they do not have the time or patience to help him achieve in activities of everyday living. Many parents are overprotective or underestimate their child's abilities. Other parents overestimate their child's capabilities or are hostile to the child because of his handicap.

Many children when removed from their home environment for part of the day have a tendency to gain a greater degree of self-confidence and physical

and emotional independence, thus making it easier for them to try activities which will help their development. Until a child loses some of his apprehension about new situations, his learning will not be up to his potential.

Many children have had a rise of 10 or more points in their IQ score while they were in our preschool program. This may stem from the fact that the program has provided them with many new guided experiences they did not have at home.

A Typical Day

A typical day in one of the program's classes would consist of—

1. Learning the skills needed to undress. Each child is taught how to take off his hat, coat, rubbers, and the like, with as little help as possible.

2. Free play—a period when the child is allowed to pursue one of many possible activities on his own. If the child is confused by this freedom, the teacher gives him a choice of two activities which are within his capabilities.

3. A group activity which is planned to help each child cope with his limitations and to develop social skills, such as sharing and taking turns. The group activity is also planned to help the child develop one of the following capacities: auditory, visual, tactual, or taste discrimination; hand-eye coordination; recall; and recognition.

4. A milk-and-cookie period. The child is encouraged to feed himself and use proper table manners if possible.

5. Nap time. Music and songs are played.

6. Active group play. The children are taught group games, starting with simple games like "ring-around-the-rosy," and working up to games which call for creative and imaginative play.

7. Quiet activity, such as listening to a story or playing guessing games.

8. Learning to dress while preparing for departure.

Each child attends the school for 2 hours a day in a class of 6 to 12 children who tend to have problems similar to his own; and, in spite of the time limitations, each child receives individual attention from the teacher during a free play period at least once a week. At this time, the teacher's aide watches the other children.

While class activities are planned around the group, the wishes, likes, and dislikes of individual children are also taken into account. The program is structured only as a means to an end—to help each child to become all he is capable of becoming—and its essence is flexibility.

Under this type of program most children in the preschool program seem to gain benefits from it even if they are not toilet trained or trainable. Many make great strides in all areas of development while

These pictures show children and teachers in the preschool center of the Cerebral Palsy Association of Western New York. At left: children in various stages of learning to dress. At right: preparing flour clay for use in a free play period.

there. While the school cannot take all the credit, its efforts in many instances may have made the difference between the child's acceptance or rejection later by a public school.

Moreover, while a child is in nursery school under the watchful eye of a trained person, other problems often come to light which have not previously been noted—for example, hearing losses, visual problems, or other symptoms of brain damage. The trained teacher by seeing the child 2 days or more a week in many varied situations is in a good position to observe signs that indicate such disabilities. Such observations lead to further inquiry and, if necessary, the child is recommended for further checking by appropriate specialists.

The majority of our children are recommended to us by the Children's Hospital Rehabilitation Center in Buffalo, N.Y., with which we work very closely. This center has facilities for evaluation and treatment through speech, occupational, and physical therapy. If our preschool staff have questions about an aspect of the development of a child recommended to us by the center, we can recommend that the child be tested there again.

The Severely Handicapped

The degree of physical involvement plays a lesser role in screening for public school entrance than the degree of measurable intelligence. Many schools will accept a child with a severe physical handicap if he has a normal or better IQ. The child who is really hurt is the one with severe cerebral palsy who scores below 50 on an intelligence test. He is not eligible for a school for the physically handicapped, nor is he eligible for a public school class for trainable children. His only resource is a day-care program, and there may not be one in his community.

We accept children who are severely handicapped physically, regardless of their IQ, if they seem likely to receive any benefit from the program and meet the requirements already mentioned.

We have, for example, a class of six children, ages 3½ to 6½, every one of whom is in a wheelchair and is almost completely dependent. Their intelligence falls in the "trainable" and "educable" range.

Even in the short span of 5 months, we have been able to help each of these children in some way. Most of them in the class were trying to use their hands more; two were learning to feed themselves a cookie and handle a cup. Every child was trying to play ball with the group and to follow simple directions. The majority were understanding more words then they did at entrance.

If these children lived in an area of the State inaccessible to our school, they might have no school training and thus no chance to play and associate with others, or to meet and experience new situations. Most of the children in this class have very little chance for achievement outside of school. If it were not for the school, they would not have had some of the following experiences:

- Field trip to Lake Erie to see the boats.
- Petting a small 5-week-old puppy and helping to mix its cereal. (Giving the child a chance to help and to learn that others need help too.)
- Helping to mix the ingredients for fudge. (Giving each child a chance to become more aware of his senses by tasting and smelling and feeling all the ingredients and the finished product.)
- Playing, achieving, and being with others in a group. (Learning social skills.)
- Handling art materials and making things with them for themselves and others.

Through providing these and many other experiences, we have helped the children to be less demanding, to have some (if only a little) idea of how it feels to help others and to do for oneself, to enjoy being with other children, and to play by themselves. Most people take such experiences for granted, but, for handicapped children, they are not within easy reach.

Our preschool staff has never regretted the program's liberal screening policy. Even when we have not been able to help a child, we have usually been able to help his parents. Through parent-teacher conferences, many parents have learned to understand and to accept better their child's limitations.

If we are asked to define our policy toward admission, it would be: that until the child has had an opportunity to fail, we really do not have any basis for rejecting him from preschool because of what we believe are deficits. We try never to forget that a handicapped child is a child first, and that the inconveniences to adults of a liberal screening policy are greatly outweighed by the benefits to the child.

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[1] Reaume, Virginia Thomas: Toilet training as a prerequisite for admission to a cerebral palsy preschool. Cerebral Palsy Association of Western New York, Buffalo. 1964.

A psychiatrist looks at the school attendance worker's task of . . .

WORKING WITH CHILDREN WHO WON'T GO TO SCHOOL

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THE ATTENDANCE officer of 30 or 40 years ago would have trouble identifying his job today. At that time, he had a rather simple, well-defined function: to get truants back to school. And truants in those days seemed also to be less complicated individuals. They truanted because they wanted to go hunting or fishing, needed to work to earn extra money by harvesting crops, or just did not like school and preferred to learn a trade. By and large, truants were not very hostile toward school and authority, and truanting even had its own ground rules, which both truant and truant officer observed.

In contrast, the attendance worker of today, who in some school systems is the school social worker, has a very complex job requiring him to deal with a wide variety of chronic and severe social and emotional problems.

At its simplest, the job involves dealing with youngsters whose families are economically and socially deprived and more concerned with keeping food in their stomachs than with schooling. Many of these children have severe learning problems because education is neither valued at home nor presented to them in their overcrowded classrooms in such a way as to give them the experience early in life of some of the fun and satisfaction that can be derived from achievements in learning.

Many of these children live in broken homes, or with parents who have been terribly defeated by the difficulties of living and, therefore, have given them little of the vital ingredients of nurturing. Such youngsters learn at very early ages to fend for themselves and to grab the pleasures of the moment, because only the moment counts in such drab and joyless existences. They resent and even hate any adult authority figure who interferes with their pleasures.

School for many such children provokes anxiety. Learning requires effort, patience, and perseverance, especially to learn enough to begin to get some pleasure out of the process. Early in their school experience, these youngsters react with increased restlessness to the teacher's insistence on learning. They escape into daydreaming or loud, provocative, hostile behavior. Removing themselves from the classroom via disturbing behavior may become an escape mechanism for them. In high school, they are among the nonreaders and nonlearners who can find no interest or purpose in school. Many turn to delinquent activities. They truant to get their "kicks" with age mates outside of school. Since they see no future ahead, no job, no security, no real purpose in living, today only is important.

Emotionally Disturbed Children

Another group of children encountered by schools with increasing frequency today are the children whose emotional disturbance is manifested through psychosomatic illnesses that keep them out of school

or through school phobia. In either case, the parents are usually intimately involved with the child's difficulties. This is perhaps most evident in cases of school phobia. In such cases, the mother usually feels great anxiety about separation from her child, who has provided most of her emotional satisfactions—satisfactions she cannot get with her husband. The child in turn reacts to the separation with marked anxiety, fears, and somatic complaints. The father generally is either passive and not very concerned about the child, or resents the child-mother duo that freezes him out. His hostility or indifference often tends to further cement the neurotic, symbiotic mother-child relationship.

The child with severe psychosomatic illness—asthma, allergies, colitis, ulcer, or even rheumatic fever—may be reacting to rather severe emotional problems in, and between, his parents, problems which have deprived him of important love and attention. The present illness gains for him at least a good deal of attention and concern, however ambivalent that concern may be.

In all of these instances, the attendance worker is confronted with disturbed and often hostile parents who unconsciously feel attacked by any discussion of their relationship to the child. These parents usually resist the worker's efforts to get the child back to school.

Yet another kind of child is the schizoid, the lonely, introverted daydreamer who tends to leave school because it frightens him. He often wanders the streets alone or sits alone near the school. He is clearly not delinquent or involved with gangs. The parents of such children are often severely disturbed people who feel rather helpless and hopeless in dealing with their child as well as guilty about their disturbed relationship with him. They frequently deny that the child presents a problem.

Helping the Parents

The worker's efforts to help youngsters stay in school involve not only conferences and work with the child, but also, and increasingly, efforts to help parents. It is around these efforts especially that referrals to social agencies and consultation with mental health professionals are sought.

Of what value are short-term efforts to help disturbed, defensive, concerned parents? The most hostile parents are those whose troubles have been so great that they have felt defeated in most areas of living. They have been unable to concern themselves much with their children and are disturbed, distraught, and helpless in the face of the child's anger and demands, or his predelinquent and delinquent activities. They want others, especially the school teacher or administrator, to act as a parent to their child and to change him into a useful, cooperative citizen.

Any demand upon them to deal with their child more effectively as parents, to be more responsible and more firm, results either in greater helplessness and anger with school personnel or in hostile, retaliatory, punitive, often sadistic action toward the child, without effecting much change in his behavior. It is difficult to help such a parent even with prolonged psychotherapeutic work. What, then, can a few interviews do?

Surprisingly, the attendance worker who can openly recognize what a difficult spot the parent is in with such a child—a child who responds to neither cajoling nor punishment—may be able to get the parent to understand how important education is for his child's future, how important for keeping the child from becoming as stuck and helpless as the parent himself now feels. This realization may come from a discussion of the opportunities that may be lost to the child who cannot read or who cannot sustain interest in tasks long enough to complete them.

An emphasis on the importance of the parents' interest in the child's schooling sometimes gives the parents a new sense of their worth and importance to their youngster. Joint interviews held by the worker with the defiant, sullen adolescent and his hopeless, angry parents sometimes give each a different view of the other and their underlying, usually unexpressed, concern for each other. After such an interview, I have heard both adolescent and parents say that they had not known that the other really cared at all. Thus, occasionally, one may help in even seemingly hopeless parent-child relationships.

Parents of phobic or psychosomatically ill children are tied to them by bonds of emotional conflict. It is important to support their efforts to understand and recognize what is best for their child, so that they can feel like good and effective parents. Thus, when the worker does not blame a parent for the child's absences from school—being blamed usually arouses parental resistance and hostility—but instead outlines the parental task necessary to help the child, he begins to reduce the parent's feeling of guilt. Then he can help the parent understand why going to school is important to the child's sense of mastery over his fears.

The emphasis on gentle firmness and persistence

for long periods of time may help parents not to be punitive out of a sense of their own helplessness and guilt. Often such help requires a step-by-step analysis of what the parent needs to do, and how the child may react to each of his moves so that the parent can understand and anticipate the child's reactions to the efforts to return him to school. Parents who are warned that the child may respond with increased illness or hysterical outbursts may be better able to withstand these difficult moments and stand pat on their insistence that the child go to school. The worker's readiness to meet with parents at moments of impasse is often of critical importance in bringing about a successful outcome.

With parents who deny the presence of disturbance in a schizoid child, there is a very serious impediment to communication. Often to get through to them requires repeated efforts by many people who know and express their concern about the child's illness. Sometimes only court action ordering a period of hospital observation for the child will activate the parents to seek help.

Use of Authority

Often, frequent interviews over a long period of time are necessary to help children with school attendance problems. However, even when the contact is brief, the worker has to help the parents to get to know him not as an authoritarian and hostile authority, but as a concerned and understanding professional person who uses his lawful authority in a benign but firm way to help both child and parents with their mutual problem.

The worker's authoritative role, his efforts to enforce the compulsory attendance law, and his potential use of a court hearing, can in many instances be helpful and therapeutic. Frequently, parents of children who truant or suffer from school phobia are unable to behave toward their children with any consistent parental authority. They permit their child to cajole them into overlooking serious misdeeds, and then, feeling guilty, punish him for trifling infractions. Or they seem to let their whim decide the issues. Or, needing desperately to be liked by their child, with whom they have a strained relationship, they excuse his truanting or other unacceptable behavior. Some parents seem to feel that being lenient about recurring misdeeds may make the child appreciate their kindness and so give them a hold over him. Occasionally, parents identify so closely with their child's defiance of authority that they are unable to be authoritative themselves.

The effectiveness of the worker's authority can only come from its judicious and consistent use. The worker must not give the child or the parent another experience of the kind of ambivalent, capricious use of authority the parents have exhibited. Such a use of authority ends in exasperation and the imposition of vindictive measures and makes impossible any real respect for authority. Through the methods he uses to enforce the law, the worker may present an example of how authority may be used with firmness and kindness to accomplish the task of returning the child to school.

Psychiatric Consultation

The ever-increasing caseload and severity of the problems presented have in many instances led attendance workers to try to use psychiatric consultation as one way of helping them cope with problems. However, the worker's relationship with mental health consultants can sometimes be rather strained. The worker may be expected by the school to deal effectively with all of these difficult problems although he knows that even the mental health expert is often not successful. Thus he may feel that to call in a consultant may mean to others that he has failed or lacks competence. When regular consultation is not available to help in the treatment plan, the consultant is apt to be called in only as a last-ditch effort to solve a problem.

As also happens in medical consultation, the mental health consultant is then expected to have the expert knowledge and special magic to solve the problem. Often, however, he has no magic and his suggestions are not new to the worker, who has already considered them. Therefore, the worker sometimes feels angry and disappointed because he has not been helped, while at the same time he may feel secretly pleased that the expert has not come up with much more than he did. His anger is always partly justified if the consultant has not been able to help him see that one value of consultation is the *sharing* of responsibility about difficult problems so that the worker will not feel alone and burdened by them.

As workers gain experience as participants in consultation, they learn that although the consultant's ideas and suggestions are often not new or even very effective, they tend to help the worker clarify his own thoughts and encourage him to try out ideas he has entertained but has been wary of attempting.

The consultant can be helpful to the worker when it is necessary to refer the child and his parents to another community resource for service. He can

help not only in determining what the appropriate resource is, but also in assessing the probable length of time it would take to bring about the desired change. This latter assessment can be helpful to the worker in dealing with school personnel who are apt to expect altered behavior in the child promptly after referral and are disappointed and angry when it is not forthcoming. School personnel frequently need help in understanding the gradualness of change and how the attitudes of the school teacher and administrator toward the child's need to learn can help bring it about.

Preventive Role

How can the attendance worker be a more effective member of the school mental health team? This is a touchy problem. The worker tends to be used in a variety of roles in the school. Sometimes he is a leg man for the administrator. Often, referring a long-term truant to him is one last effort before an expulsion or suspension already predetermined in the administrator's mind, thus allowing him little opportunity to work with the child and his parents. In some instances, the worker, without having had any contact with the child or parents, is told to take the case to court.

The preventive function of the attendance worker is rarely called upon. He is not often included as part of the school team of administrator, teacher, and school nurse which evaluates children whose behavior and learning difficulties indicate that they may be potential truants. He is rarely asked to work with such children and their parents early in the difficulty or early in the child's school experience.

Thus in each of his cases the worker has the dual job of apprising the school personnel of what might have been done had the child been referred to him earlier and of demonstrating how the teacher may help keep a child in school by giving more attention to his learning problems and calling on the attendance worker to work with his parents.

Adult Models

In working with truants, the worker must keep in mind the kind of models these youngsters need in the adults around them—grownups who are neither punitive nor patsies, whose understanding of children leads them to be firm, fair, and consistent in their attitudes, realistic in their evaluations of the child and his situations, and hopeful about a human being's ability to change. These youngsters need to experience adults who, unlike their parents, neither fool themselves nor are conned by a child's false promises. They need a person who is convinced of the importance of the child's remaining in school and who, at the same time, realizes the difficulties for the child and teacher in getting any learning started, caused by the obstacles in the child's home environment and the grim realities of today's crowded classrooms. Such conviction and reality assessment, when communicated to children and teachers, sometimes begin to help them to try it again, and perhaps again, and to stick to it a bit longer each time.

In the case of the phobic or psychosomatically ill child, the worker needs to adopt a determined persistence with child, parent, and school so that the child will begin to feel in his bones that he has to go to school, that, if necessary, he will be taken to school. Only consistent authoritative efforts help both the child and the parent who has abandoned the authoritative parental role.

The prepsychotic, schizoid youngster desperately needs psychiatric help. Sometimes the worker's awareness of the problem and his sensitivity to the youngster's needs provides the child with valuable stopgap attention until his parents are able to seek aid from a clinic.

In Conclusion

For an attendance worker to use a mental health consultant is *not* a sign of inadequacy and incompetence. On the contrary, it reveals mature thinking designed to make a difficult job more manageable.

The consultant's function is not only to supply some insights from his particular field of work, but also, and most important, to provide a noninvolved, fairly objective perspective toward problems. Often, solutions can be found by the worker once problems are discussed from a new vantage point.

The attendance worker, in turn, has certain obligations to the consultant: (1) to educate the consultant about the worker's job, so that he understands what and how the worker functions, what pressures the worker is under, and from whom; (2) to help the consultant understand the school setting more fully, the people involved, and what they contribute to the child's, parents', and worker's problems; (3) to learn to use the consultant well—to assess the kinds of problems the consultant is most helpful with, and to see if, together, worker and consultant can learn to collaborate more effectively on the others. If the worker carries out these obligations, he will be helping the consultant to grow into a more helpful colleague in the venture of keeping children in school.

A research-oriented demonstration in . . .

CROSS-AGE RELATIONSHIPS— AN EDUCATIONAL RESOURCE

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AT THE INSTITUTE for Social Research, University of Michigan, we have begun to probe into areas of relationships between children of different ages.

Over the past 3 years, we have carried through a series of pilot projects in two elementary schools—first in the University of Michigan laboratory school and later in several biracial classes in a public school in a neighborhood of blue-collar workers—and in a summer day camp for boys and girls from 4 to 14 years of age.

In these pilot projects, we have attempted to determine what is required to implement a constructive program of cross-age interaction; and have begun to collect data on, and evaluate the impact of, the perceptions children have of other children who are older and younger than they are.[1]

The process of educating children can be divided into two interrelated parts:

1. A process of socialization, whereby the child learns, internalizes, and practices certain patterns of values, attitudes, and expectations which have important implications for his behavior.

2. A process of subject-matter learning, whereby the child acquires and learns to use information and problem-solving skills to achieve some degree of mastery over the major domains of knowledge.

In our society today, the major responsibility for helping children acquire the skills, attitudes, and values necessary to function successfully as adults has been placed in the hands of parents and educators. This model of a few adults and teachers working with, and being responsible for, such a complex learning program presents serious difficulties. There are limits to the amount of individualized attention the learner can receive when the major weight of all learning transactions is placed on the relationship between adults and a large group of youngsters.

We may not be making the best use of the powerful potential educational resource represented by cross-age relationships among children. It is an observed fact that children, with proper training and support from adults, are able to function effectively in the roles of helpers and teachers of younger children—and that the older children find this type of experience meaningful, productive, and a source of valuable learning for themselves.

Most children are involved from a very early age with older or younger siblings, or both. In preschool neighborhood life there is usually a variety of significant cross-age relationships. Cross-age interaction is probably a potent learning experience for children of all ages.

For instance, a child observes how children older

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than he cope with adults; what the older ones are able to do; what they are permitted to do; and the fact that children younger than he seem to get more attention from adults. Furthermore, he learns how to cope with, or avoid, the greater strength and sophistication of older children; to exploit the younger ones; and to avoid the sanctions of adults for mistreating children weaker than himself. He learns that his age-graded classmates are supposed to be regarded as his equals. He develops his conceptions and expectations about the different levels of "grown-upness," and what they mean in terms of privilege, responsibility, and skills.

Five Assumptions

One assumption underlying our pilot projects has been that much of the process of socialization involves use by younger children of the behavior and attitudes of older children as models for their own behavior. This process has great potentiality for planned development as an effective educational force, provided that children are trained appropriately for their roles as socialization agents.

Some of the important natural components of this cross-age modeling process include: an older child's ability to communicate more effectively than adults at the younger child's level; the fact that an older child is less likely to be regarded as an "authority figure" than an adult would be; the younger child's greater willingness to accept influence attempts when he perceives a greater opportunity for reciprocal influence; and the fact that a slightly older child provides a more realistic level of aspiration for the younger child than an adult would.

A second assumption of our projects has been that involvement of older children in a collaborative program with adults to help younger children will have a significant socialization impact on the older children because of (1) the important motivational value of a trust- and responsibility-taking relationship with adults around a significant task, and (2) the opportunity to work through—with awareness but at a safe emotional distance—some of their own problems of relationships with their siblings and peers.

A third assumption has been that assisting in a teaching function will help the "teaching students" to test and develop their own knowledge, and also help them discover the significance of that knowledge.

A fourth assumption has been that both younger learners and their adult teachers will be significantly helped in "academic" learning activities through the utilization of trained older children available for tutoring, drilling, listening and correcting, and other teaching functions.

A final assumption has been that a child will develop a more realistic image of his own ability and present state of development, and will gain a greater appreciation of his own abilities and skills, if he has an opportunity to help children younger than himself to acquire skills which he already possesses and to develop positive relationships with children older than himself.

Children's Perceptions

There is a circular process in cross-age interaction. The feelings and attitudes of the older child affect both his intended behavior toward the younger one and his expectations and perceptions of the young child's behavior toward him. At the same time, the way the younger child sees the older child's actual behavior is evaluated by the younger child and, combined with his other attitudes, affects his attitudes and his intended and actual behavior toward the older child. Then the younger child's behavior, as perceived by the older child, produces feedback (information which enables the older child to compare his expectations of the younger child's reactions to his behavior with the actual effects of his behavior on the younger child), and this further influences the older child's attitudes toward the younger child.[2]

In response to questions asked in our pilot studies, children discussed their perceptions of children older and younger than themselves.[1]

In general, we found that both boys and girls perceive older children (called "olders" in our project) positively when the olders include them in their activities, or are friendly, or offer help or recognition. On the other hand, the younger children ("youngers") appear to have a great deal of ambivalence in approaching olders, whom they so often perceive negatively as exploitive, hostile, or domineering. Considerable distrust is engendered in these relationships because the olders typically perceive the youngers as incompetent, and exclude them from rewarding patterns of interaction.

Boys, particularly, perceive younger boys to be incompetent and demanding too much of their time and resources. On the other hand, boys perceive youngers positively when the youngers are competent enough to participate in activities that the older boys like, or when the youngers will help them or submit to their influence.

Older girls, on the other hand, appear to experience

youngers positively as objects for nurturing; or negatively, as teasing and demanding too much attention.

These perceptions, we believe, tend to reflect experiences encountered and attitudes and values learned as the child is socialized into his appropriate sex role in our culture. When such patterns of attitudes and expectations have ambivalent or negative components, they tend to discourage any tendency toward interaction among children of different chronological ages or developmental levels. Simply providing opportunities for children of different ages to interact, therefore, is not a sufficient condition for the development of growth-supportive patterns of cross-age interaction.

What is needed is a program of education or training, providing opportunities for children to gain insight into their own attitudes and those of others; a chance for them to practice skills of giving and receiving help; and the development of situations making it possible for them to examine and understand the consequences of their own behavior on the behavior of others.

Therefore, we have designed a plan for such a program. This draws mainly upon our experience in the two schools—the university laboratory school and the biracial public school. We believe, however, that each of the program elements we have outlined for the school have parallels in other settings.

Program Elements

In our school pilot projects, sixth graders were involved as academic assistants in the fourth, third, second, and first grades. They helped children in the younger classrooms with reading, writing, arithmetic, spelling, and physical education. In addition, they were used as laboratory assistants in social science laboratory periods, working as group-discussion leaders and producing "behavior specimens" presented for observation and study.

Their success was the result of several carefully planned steps in the development of collaborative cross-age interaction.

1. ***Providing opportunities for cross-age interaction through collaboration between adults.***

First, the project coordinator and the teachers involved in the project held an orientation session to discuss the opportunities the program could offer, not only for the growth and development of positive relations between the children of different ages but also between the teachers of different grades.

". . . a child will develop a more realistic image of his own ability . . . if he has an opportunity to help children younger than himself to acquire skills that he already possesses. . . ." Here a sixth grader helps a younger child with his lessons.

The project was presented as one in which no teacher was giving up his authority over his class, but rather was lending the resources of his children to benefit both youngers and olders individually—and each class collectively. The concerns each teacher had for his own class were discussed, as were ways in which the project might help his children reach their individual goals, and, in addition, help the teacher to reach his goals for the class as a whole.

The project staff then met weekly for planning, discussion, and evaluation. A schedule was developed for times during the school day when the helping children, five or six in a squad, could be trained in skills of relating to younger children, also in skills in the teaching of content material; periods when the helpers would be in the youngers' classrooms; and periods when the teachers could have discussions with the student helpers about their pupils' progress.

2. ***Teacher-student collaboration.***

Teachers then explained the purpose of the project to the sixth-grade classes. There was discussion of how difficult it is for one teacher to give a great deal of individual help in her classroom. The role of the older students in the project was described in terms of the unique contribution which these students could make in helping younger children to learn.

In this and subsequent meetings, an attempt was made to develop a partnership between the teacher and each helper which would encourage mutual par-

ticipation in goal-setting and the planning of strategy.

3. ***Building a peer-group attitude which supported the value of helping youngers and being helped by olders.***

One significant aspect of child life which tends to prevent constructive relationships between older and younger children is the fact that in the usual peer culture of children, no status can be gained by treating youngers with anything but hostility or avoidance, coupled with the resulting assumption of the younger children that older children do not like them and cannot be trusted.

In order to change this state of affairs, which may not be enjoyed by either group, it is necessary to build within both older and younger classes of children an influential peer group which looks upon the idea of giving help as an attitude producing status and rewards.

This was done in our project by putting children held in high regard by their peers in the first two groups of sixth graders to be trained to relate to younger children; and by having the training and briefing of these children given at such a time and in such a way as to establish clearly that some glamour was connected with it.

In addition, a panel of four of the seventh graders with high peer status, who had had experience in the sixth grade the year before as trained helpers with the junior kindergarten, talked to the sixth graders about the advantages that they had perceived for themselves in this helping relationship. They taped this talk to be used for the sixth graders who were going to be helpers in the other school. The seventh graders also made and taped a different talk for the fourth graders, explaining to them the advantages which the fourth grade would be giving the sixth grade in allowing the sixth graders to help them. This was to show the younger children that the help was not just one-way: that the fourth graders had much to contribute to the older group which the latter might never get in any other way.

4. ***Training for the helper role.***

These first two groups of helpers from the sixth grade, and subsequently the other members of the sixth-grade classes, were carefully trained in how to relate to younger children, and briefed in their specific jobs. This was accomplished through—

Seminars. Here the olders learned, through discussion and role-played episodes, how to approach youngers constructively, and how to help youngers to accept instruction. They learned what levels of expectation were realistic for children of a particular age, and for the individuals they were to help. They learned the techniques of correcting errors in encouraging, rather than discouraging, ways. They practiced giving praise without lowering performance standards. They practiced methods for taking youngers from the levels at which they were successful to higher levels.

Training in academic procedures. After the older children had had some orientation to younger children, they had a training session with the teacher whom they were helping. The teacher explained how the drill—or whatever she had planned for the olders to give—would help the younger children learn. She explained to the olders how they were to carry out the assignment; and, to see if they understood the method and procedure before teaching a younger child, gave them practice in working with each other.

Feedback sessions. The older helpers worked 2 and sometimes 3 days a week with the same child for 2 consecutive weeks—each session lasting from 20 to 30 minutes, depending on the age and attention span of the child being tutored. Before beginning the second week, each helper had a feedback session with the teacher of his child to report what progress had been made, and to get an assignment for the next week's sessions.

5. ***"At-the-elbow" help.***

When the helper met for the first time with the child he was going to help, a teacher was nearby to give him "at-the-elbow" help if needed.

One fourth-grade teacher had her sixth-grade assistants come in a half-hour before school, to work with children to whom they were giving help. Because only two or three helpers were working at the same time, it was possible for the teacher to keep an eye on how things were going and to make suggestions.

Most of the tutoring was done during the same time that the rest of the class was studying the subject—as in a reading period or arithmetic class. The helper would work closely enough to the teacher for her to make suggestions.

An example of at-the-elbow help on the first day of tutoring occurred when neither the pupil nor the helper knew the meaning of a certain word. The teacher came to the rescue with "Jim, did you know all my fourth graders have a dictionary in their

desks?" Jim picked up this lead. "Say! A dictionary of your own! That's great. Let's look it up."

At-the-elbow aid, in the early stages, helps the helper to become confident in using his newly acquired teaching techniques. It gives him the same feeling of success that the teachers want him to inspire in his pupil. At the same time, it lets the teacher keep a quality control on his performance.

Beneficial Outcomes

In the course of our pilot studies, we have asked teachers and students to comment on their experiences. One teacher reported on Bob and Ted, two of her fourth graders:

"Bill was to help Bob choose and read a library book. After successfully finding a book on Monday, the boys returned to the room and began reading it. Bob became so interested that he did nothing but read his book all day. Bill returned on Tuesday morning to see how far Bob had progressed, and was surprised to find that he had covered four chapters. Bill took out some phonetic 'flashcards' and showed Bob a method of analyzing words. Bob was very enthusiastic about finishing the book and getting another. This was a complete change in Bob's attitude toward reading. Previously, he had had no interest in reading a library book.

"Ted has responded very well during the past 2 weeks. He finished his arithmetic assignment and is more alert to everything going on. The added personal attention motivates him to read, to do his arithmetic, and to want to get his work done."

Another teacher reported:

"The status of boys and girls in their own classroom has been increased by special attention from sixth graders. Fourth graders have learned that trained sixth graders can be of great assistance. The added drill has increased the learning of my slow group, and has given them a better feeling about themselves. The limited enrichment program provided by sixth graders has motivated top pupils and middle pupils to do more and better work."

A majority of the older students were eager to be involved in this type of helping program. This was particularly true of low-achieving students, of lower socioeconomic status. Their relationship to adult authority figures (their teachers) was improved and their motivation to learn increased. A sixth-grade teacher reported:

"I was the at-the-elbow supervisor for physical education helping. Three sixth grade-fourth grade pairs, in basketball and tumbling, were working simultaneously. It was the second or third time for most of them. It was as perfect an example of this kind of fieldwork as could be hoped for. The helpers and the fourth graders had a sense of accomplishment as they practiced. With good preparation of the helpers, a large number of pairs might very well work with only one supervisor after the first period."

Another teacher, of an older group, reported:

"The children return from helping sessions with an increased will to do well in their own work. This has made more effective the time spent on the work in class. It has increased the self-respect and belief in their own ability of all of my defeated children, thereby contributing much to making them capable of learning."

The older children have given reports indicating that they have obtained deep personal satisfactions in this type of helping opportunity, and have gained insight into themselves and others. For example:

"They [kindergarteners] also have troubles. You wouldn't think they had troubles. Everyone has problems. They don't like to be told what to do. They want to make up their own minds."

"Sometimes everyone thinks teachers are real mean and you realize now they just try to help you."

In one seminar, sixth graders were asked what they would say to a shy child who, daring to show aggression for the first time, said: "I'm a hippopotamus, and I will bite you." One boy answered: "I'm a tiger, and I am your friend"; and another, "I am a baby hippopotamus, and you can take care of me."

New Opportunities for Children

As we have continued to work with children, teachers, and counselors on utilizing the resources of older children in educational and related settings, we have been impressed and gratified by the enthusiasm with which both children and adults have reacted to this experience.

In a society in which motivation to learn is an increasingly critical issue, and in which service roles are the most rapidly expanding occupational areas, there is an urgent need to provide youngsters with opportunities to engage in relevant and meaningful service activities during their school years.

This places an obligation on those working with children to find new ways of providing them with opportunities to take initiative and responsibility, to test out newly developing skills, to learn about the gratifications of achievement and of helping others to achieve, to develop skills of relating more effectively to others, and to develop an appreciation of the value of understanding themselves and others.

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[1] Fox, R. S.; Lippitt, R.; Lohman, J. E.: Teaching of social science material in the elementary school (final report on Cooperative Research Project E–011, U.S. Office of Education). Institute for Social Research, University of Michigan, Ann Arbor. 1964.

[2] ———: The innovation of classroom mental health practices. In Innovation in education. (Matthew Miles, ed.) Bureau of Publications, Teachers College, Columbia University, New York. 1964.

UNMARRIED MOTHERS WHO KEPT THEIR BABIES

ELLERY F. REED

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THE seriously disadvantaged status of many unmarried mothers who keep their babies was evident in a study made recently in Cincinnati, Ohio, of 118 unmarried mothers who kept their babies.[1] In spite of these disadvantages, the investigators found that most of the mothers, if they had the decision to make again, would keep their babies.

The study was carried out by Social Welfare Research, Inc., YWCA, Cincinnati, through personal interviews by caseworkers and the study of social agency records. Because of the impossibility of selecting a "typical" sample, it was based on cases that could be found through social agencies and in which the mother was willing to cooperate. The agencies were: the Hamilton County Department of Welfare, three private maternity homes, and the Catholic Charities Archdiocese of Cincinnati. More than half the mothers had been residents of maternity homes. By design, no mother was included in the study who had more than two children: 90 percent had only one child. Two-thirds of the mothers were white.

Forty-seven (40 percent) of the mothers were receiving financial assistance through the Department of Public Welfare. Twenty-two (19 percent) were dependent on parents or relatives. The remaining 49 (41 percent), including 16 who had married, were financially "independent." Some of these, however, were living in conditions of real proverty and deprivation. They were not eligible for public assistance because the public assistance grants were based on 70 percent of a minimum budget. Those who were on public assistance received little casework service because of the large caseloads.

The mothers ranged in age from 15.5 years to 47.5, but the large majority were 18 to 25 years of age. Twenty-nine were in the age group of 25 or over. Only 8 were under 18 years of age.

Only 32 of the 118 mothers had completed high school; 3 had had some college work. Fifty-three had completed only part of their high school education. Twenty-six had completed only the sixth, seventh, or eighth grades, and 4 had had even less education. Only 15 of the entire group had had any vocational education.

Mothers and Children

Thus, in general, these unmarried mothers on whom rested the heavy responsibility of a child were poorly prepared educationally to support themselves, to say nothing of their babies.

Less than 30 percent of the mothers were employed. Twenty-five of the 34 who were employed worked 40 hours a week or more. Restaurant and factory work were most common. Only 11 earned $50 a week or more. The baby's grandmother in 15 cases was taking care of the baby while the mother worked. Other relatives gave this care in 4 cases, and other persons or agencies in 15 cases.

Most of those who were working before birth of the child did not return to the same job afterward.

Approximately half of the mothers were living in single-family-house neighborhoods where the general condition of the housing was rated as good or fair. Of the half who were not in adequate housing, 23 lived in a house or apartment unit which had no bathroom. In 9 cases there was no indoor toilet in the building. In 35 cases there was no central heat.

The great majority of housing units did have hot as well as cold running water, but eight did not. In the majority of cases the laundry facilities were rated as good or fair.

Physical examinations were secured for the babies but not for the mothers. The majority of the mothers (85 of the 118) reported that they had had the regular 6-week medical checkup for the baby; 104 of the babies had been immunized against diphtheria, pertussis, and tetanus; 86 against smallpox; and 46 had had other types of preventive health care. However, 26 of the 118 babies examined were rated by the examining physicians as needing some medical care.

Psychological tests of 115 of the children indicated a fairly normal distribution of IQ's. A majority (79 of the 115 examined) were included in the IQ group, 90 to 109. Twelve had IQ's of 110 to 119 and 4 had 120 or over. Five had IQ's of less than 80.

Twenty-two of the mothers were now

married; 8 to the child's father. Of the remainder, 23 said they dated frequently, 29 occasionally, and 44 not at all. Dating was more frequent among the white than among the Negro mothers. The interviewers found that some mothers who said they did not date at all understood the term to mean literally "going out with a man," and not to include entertaining a man at home. Some mothers who said they did not date were again pregnant.

In the majority of cases the dating was not with the alleged father. Few of the alleged fathers—whether middle or lower income or dependent, white or Negro—showed any consistent interest in either the mother or the baby. Only 25 contributed at all to the child's support. Of these, 9 contributed voluntarily and 16 under court order. In most cases the support was inadequate or irregular.

A majority of the 22 marriages were represented by the mother as happy at the time of the interview; and 17 of the 22 husbands were reported to show consistent interest in the baby. Thirteen of the 22 men had full-time employment; the others had only part-time employment or none at all. Only six had finished high school.

Most of the mothers reported attending church only occasionally or not at all; 26 said they attended regularly. Only 27 said they were participating at all in church recreational or social activities and only 6 of these said they were doing so regularly. However, 33 mothers reported that a clergyman had established a pastoral relationship with them, and 25 of these said they had found this helpful.

The majority of the mothers said they had kept up with at least some of their friends, but 24 had not maintained contacts with any of their former friends. Only half the mothers (59) said they had made new friends.

Some of the mothers laid their difficulty in keeping in touch with their friends to the fact that they had no one with whom to leave the baby. Lack of bus fare was also mentioned.

Only 24 mothers said they enjoyed reading. Four could not read at all and several found reading so difficult that it was not enjoyable for them. Forty-eight mothers kept their radios or televisions going 4 hours or more per day. Thirty-six mentioned other hobbies.

Why They Keep Their Babies

Problems of support seemed to have had little weight with most of the mothers as a consideration against keeping their babies. The idea or possibility of placing the baby for adoption had apparently never occurred or been presented to many of them. For the Negro mothers the opportunities for placing their babies for adoption were slight, and so there was less reason for this idea to receive consideration. Some mothers, including both Negroes and whites, seemed to have strong convictions that it would be wrong to give up the baby to anyone else. Many of the unmarried mothers of lower socioeconomic status apparently felt little social stigma or embarrassment about their unmarried status.

Emotion, rather than realistic considerations for the welfare of the babies and themselves, seemed largely to determine the choice to keep the baby in those cases in which there was a choice. The mothers made such remarks as: "Could I cast away my own flesh and blood?" "I'd grieve myself to death if I let my baby go." Some indicated that the baby would provide them with an interest in life—"something to live for." Some said they had hopes of marriage. Some hoped if the father saw the baby he would change his mind and marry them.

The great majority of the mothers (101 out of 118) said if they had the decision to make over again they would again keep the baby. This held for every group—white and Negro, middle and lower income and dependent groups. (The study found only one mother classified as belonging to the upper economic class who had kept her baby.)

Parental influence was mentioned by 24 mothers as a factor in causing them to keep their babies. Two mentioned the influence of a clergyman.

The findings of this study constitute a challenge to both public and private health and welfare agencies. Most of these mothers were in need not only of social services and adequate financial assistance but also of other community services, including those dealing with health and housing, education, recreation, and religion. Unless they receive such help, their future (and the future of their babies) is likely to hold continuing poverty, dependence, delinquency, and poor opportunity.

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[1] Reed, Ellery F.; Latimer, Ruth: Study of unmarried mothers who kept their babies. Social Welfare Research, Inc., YWCA, Cincinnati, Ohio. 1963.

There is some danger in the current usage of the term "culture of poverty" because it suggests that something other than absence of money distinguishes the poor as a *group* from the rest of us. It is true that poverty is discouraging, debilitating, and cuts people off from the mainstream of American life. But there is a danger in suggesting that these qualities are intrinsic to the poor themselves rather than the end-product of remediable social ills. The danger lies in the ease with which this assumption moves toward the charge that the poor are poor by their own fault.

Elizabeth Wickenden, Technical Consultant on Public Social Policy, National Social Welfare Assembly, in* "Notes on Poverty: Cause and Cure," *a memorandum prepared for the assembly, 1964.

HERE AND THERE

Conference on Group Care

In an effort to determine under what conditions it may be feasible to establish a demonstration in group care for infants and young children in Metropolitan New York, under the Federal child welfare research and demonstration grants program, the Children's Bureau held a small 1-day conference in Washington, D.C., in late January.

Besides selected staff from the Children's Bureau, the conference participants included representatives from the New York City Department of Welfare, the Citizens' Committee for Children of New York, the Child Welfare League of America, the United Nations Bureau of Social Affairs, the New York School of Social Work, the New York Fund for Children, the Upstate Medical Center of the University of New York at Syracuse, the Children's Hospital of the District of Columbia, and others concerned with finding ways of providing care for young children whose parents are unable to provide it.

Among the facts and expressions of opinion brought out in the conference:

• Estimates indicate that 270,000 children in this country live in some kind of foster care; of these, 77,000 are living in institutions. There are 9,000 children less than 6 years of age in group care and almost 2,000 of them are less than 1 year old. In addition, 7 cities with populations of 100,000 or more report a "problem" of well babies remaining in hospitals because there is no place for them elsewhere.

• In New York City, there are 22,000 children away from their own homes in care of the Department of Welfare, with approximately 1,500 awaiting care. The incidence of family breakdown is swollen by the economic and housing problems of in-migrants from the South and from Puerto Rico; and the difficulty of finding foster parents is enhanced by the scarcity of space in normal living quarters. The problem of providing care for children is exacerbated by the absence of any comprehensive planning for child care in the city; lack of sufficient funds or authority for providing care; confusion of responsibility between public and voluntary agencies; and failure over the years to test what is effective in the foster care field.

• In all parts of the country, many children are kept in "temporary" institutional care year after year, awaiting opportunities for a more permanent arrangement. While controversy rages between the proponents of foster family care and institutional care, insufficient good care of either type exists. Too often, comparisons are made between poor institutions and good foster homes, or between poor facilities of either type and good "own" or "natural" homes.

• While more recent studies of foster family care indicate that many children in such care do poorly, such findings may be compared to those of a previous decade in which institutions were found to be a sterile and depriving atmosphere for children. What all these studies have in common is that poor care, whether individual or group, leads to serious negative consequences for the child. What is needed to meet the differential needs of the many children in the care of child welfare agencies is improvement in all forms of child care as well as development of new forms.

• With more funds, innumerable innovations could be introduced and more and better families could be recruited. Homemaker services, casework, financial assistance as needed, a fair board rate, improved "working conditions," and "fringe benefits" could improve the quality and availability of good foster homes.

• Even with all these improvements there still would be a need for group care and a need to know which children need which form of care.

Descriptions were given of two research and demonstration projects in group care of infants and young children being supported by the Children's Bureau: the Children's Center of the Upstate Medical Center at Syracuse, N.Y., which provides day care and services to parents in a low-income area; and a program still in the planning stage at the Yale University Child Study Center, which will attempt to compare the effect on children of group residential care, foster family care, and the provision of services to children in their own homes. Also described was a project dealing with the care of infants at the Children's Hospital of the District of Columbia, supported by the National Institute of Mental Health.

The conference arrived at the consensus that "it is time for New York City to set up a research and demonstration program for group care of children, including infants." There was further agreement that such a demonstration should be under the auspices of the New York City Department of Welfare, which has a wide variety of resources as well as primary responsibility for infants and children in need of child welfare services. It would be research oriented and would draw on what is known about the developmental needs of infants and young children, on the one hand, and about group care on the other, in providing care for children who cannot be reared in their own homes, who need long-term care, and who are now either minimally served or actually damaged in the first months or years of life.

One of the unresolved questions was whether a group care program could be designed for very young children which would take into cognizance the child's need for continuity of care as he grows older.

Further discussions of methods of implementing the project are being held by a working committee of the conference participants.

—Charles P. Gershenson

Day Care

Pointing out that the Public Welfare Amendments of 1962 emphasized day-care services as part of the broad range of public child welfare services, the Commissioner of Education and the Commissioner of Welfare, Department of Health, Education, and Welfare, recently issued a joint statement of agreement on the functions of day care as a child welfare service and preschool education as part of an educational program.

Purpose of the statement was to provide guidelines for the Federal agencies charged with the development of programs for preschool children—especially the Welfare Administration,

which is concerned with the development through the Children's Bureau of day care as a part of child welfare services, and the Office of Education, concerned with the development of preschool education as a part of a total education program. The Office of Economic Opportunity is interested in encouraging both types of programs through its community action grants.

The essential function of day care as a child welfare service is described in the agreement as giving "care and protection to children as a supplement to parental care." The statement points out that such care is for "children who must be outside their own homes for part or all of the day because their parents are working or seeking work or otherwise absent from the home or unable for other reasons to provide adequate parental supervision." This service, it asserts, may be given in another family's home, or in a day-care center "for children who can benefit from a group experience." To be adequate, the statement maintains, the service "must combine the services of health, education, and welfare—services fundamental to the growth and development of the child."

The statement points out that the purposes and the reasons for which a child and family need and use the service distinguish a day-care service from such educational programs as nursery schools and kindergartens. "The essential function and purpose of preschool education," it states, "is the training, education, and development of the child."

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In Seattle, Wash., a group of licensed foster day-care mothers have formed an organization, the King County Chapter of Day Care, devoted to continuous improvement of their child-care responsibilities. The chapter resulted from the course for foster day-care mothers sponsored in King County by the Washington State Department of Public Assistance. Composed of some 30 members, it holds regular meetings, sponsors institutes, publishes newsletters, and provides the department with some volunteer clerical services to help in the efforts to upgrade and expand foster family care in the county.

The course out of which the organization grew was the first of a series of eight-session "lecture-discussions" initiated by the department's day-care specialist in 1963. Topics of the sessions were: (1) new dimensions in foster care; (2) emotional, physical growth and development; (3) experimental theories in child development; (4) encouraging creativity in children; (5) safety in the home; (6) insurance information; (7) the legal aspects of day care; and (8) early recognition of emotional disturbance in children. Among the community resources which sent representatives to conduct the sessions were the Family Life Education Association, the Childbirth Education Association, the University of Washington, the local fire and public health departments, the American Red Cross chapter, the local office of the Internal Revenue Service, and an insurance company.

Participation in the educational course, now in its fourth series, is on a voluntary basis, the participants being referred by the department's caseworkers or by members of the King County Chapter of Day Care.

In addition to the educational course, the department holds weekly orientation sessions open to anyone interested in foster day care and required of all applicants for licenses.

. . .

As long as day care of children is regarded exclusively as a diagnostically selective therapeutic social service for children, rather than as a "developmental provision" to enhance child rearing, day-care services are not likely to expand to meet the needs of mothers and children in the socially and culturally deprived centers of our large urban areas, according to the report of a study of day-care programs in New York City recently made under the auspices of the Columbia University School of Social Work. ("Day Care as a Social Instrument: A Policy Paper," by Anna B. Mayer with the collaboration of Alfred J. Kahn.)

Granting that the expansion of the therapeutically oriented type of day-care service is needed as an important child welfare resource, the report emphasizes the further need for a more broadly inclusive preschool program with a comprehensive child development focus for 3- and 4-year-olds. It recommends an educationally based program of neighborhood "beginners' day schools" in which the disciplines of health, education, and welfare are synthesized "rather than merely coordinated." Such schools would be flexible in the length of the child's day and would provide a year-round service. They would not require that the child have a "working mother" or any other means test for admission.

The authors anticipate some opposition to such a new "social utility" from those forces "dedicated to . . . the economic and social needs tests" and other limitations which, they maintain, restrict services to a small portion of those needing them.

The report estimates a need for space for 40,000 children in such a program in New York City. It points out that, at present, there are 5,000 children in publicly supported day-care centers; 11,000 in voluntary commercial or sectarian programs; and 1,500 in board of education preschool programs.

Homemaker Service

The development of a code of standards for homemaker services was the focus of a 3-day workshop held by the National Council for Homemaker Services in Princeton, N.J., March 10–12, with cooperative sponsorship from the Children's Bureau and the Bureau of Family Services, Welfare Administration, and the Public Health Service. The 60 participants included social workers, nurses, home economists, physicians, specialists in education and community organization, and representatives of governing boards of agencies providing homemaker services from all parts of the country. Many of them were members of the council's committee on standards and its six subcommittees which have for several months been studying existing agency policies and developing statements for consideration as parts of the code.

The discussion at the meeting centered on these tentative statements. Recommendations for revisions and additions were made and will be incorporated by the committee on standards in a preliminary code to be presented for further discussion at the 1965 forum of the National Conference on Social Welfare at a session on May 25 entitled "Homemaker Services Circa 1965."

The committee on standards consists of representatives of 17 national health and welfare organizations and 3 consultants from the U.S. Department of Health, Education, and Welfare, in addition to the chairman, who is a board member of the National Council for

Homemaker Services. The subcommittees are composed of members of the committee, plus 40 additional people directly concerned with homemaker services.

The goal for the code is one that is comprehensive and flexible enough to be applied by the various types of agencies providing homemaker services, but will still assure a high quality of service. The six areas of responsibility selected for inclusion in the code are: (1) purpose and function; (2) organization and administration; (3) records; (4) training and continuing education; (5) staffing; (6) community relations.

Against Poverty

Some 200 home economists from various occupations and geographical areas met in Chicago for 5 days in mid-March to learn more about the problems and needs of low-income families and the agencies serving them, and to discuss ways of applying their special skills and services to the welfare of such families. Sponsored by the American Home Economics Association, the workshop was the first step in a plan to help home economists throughout the country play a greater role in improving conditions among the poor.

The participants came from five types of settings: college and university teaching and research; elementary and secondary education settings; health and welfare programs; cooperative extension services; and business firms. Each agreed to take responsibility for extending the message of the workshop to other home economists by helping to develop one area or State workshop of a similar nature.

In the meetings, the home economists were encouraged to develop long-term as well as short-term crash programs to help families break out of the poverty cycle. Their goal, as identified for the workshop in a message from Sargent Shriver, Director of the Office of Economic Opportunity, is to "bring unity, strength and hope to the impoverished family. . . ."

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A recent study of the AFDC caseload in 10 Texas counties showed that more than 70 percent of the families receiving aid to families with dependent children had income other than their AFDC grants, a fact which the investigators maintain opens to question the "mythology" that families receiving public assistance are unwilling to provide for themselves.

Supported in part by a grant from the Vocational Rehabilitation Administration, U.S. Department of Health, Education, and Welfare, the study was carried out by Morris Kagan of the University of Texas School of Social Work; Patricia P. Hakes of the Austin Community Guidance Center; and Maurine Currin of the Texas State Department of Public Welfare. They found that the presence or absence of supplementary income was not significantly related to the length of time the family had received assistance.

The study indicated that most of the AFDC recipients who contribute to their own support are still unable to meet their needs adequately: 77 percent of those with supplementary income still had unmet financial need after receiving the AFDC grant, as had 83 percent of those without supplementary income. The investigators regard this as an indication that the rehabilitative purpose of AFDC is not being accomplished.

The investigators also found a flaw in the idea that mothers in families in which the AFDC payee is a male are more likely to contribute to the family's support because of having a convenient baby sitter in the home: only 25 percent of the mothers in the families with male payees are working, as against 55 percent of the mothers in the families with female payees.

Nurse-Midwifery

Although nurse-midwives are employed in a variety of positions, only 34 nurse-midwives in the United States are *practicing nurse-midwifery*, according to the definition of this occupation arrived at in a study recently completed by the Children's Bureau. As part of this study, the investigator compiled a list of 630 names of nurse-midwives prepared or working in the United States, 95 of them known to be working outside the country now. Of the 501 who were in this country and not practicing nurse-midwifery, the majority were in positions in which their knowledge of midwifery was used to some degree.

The study, which was made on the recommendation of the Association of State & Territorial Health Officers, focused on both the extent and nature of nurse-midwifery practice in the United States. The extent of practice was determined in cooperation with the American College of Nurse-Midwifery, by correspondence with schools of midwifery, and through announcements in nursing journals. The nature of the practice was determined by interviews with 30 of the 34 practicing nurse-midwives and with 32 physicians and 12 administrative nurses associated with these nurse-midwives in their practice.

Statements related to physicians' and nurse-midwives' responsibilities in desirable practice were developed, and each respondent was asked to reply to each statement in two ways: "Does the statement apply to the situation in which you work?" and "Do you think it is a sound statement which should apply wherever nurse-midwives practice?"

Among the findings:

- There was full agreement among the respondents that nurse-midwifery practice should be administratively affiliated with medical practice.
- There was substantial agreement among all types of respondents that the physicians would be expected to (1) screen all patients for those suitable for assignment to nurse-midwives for care; (2) maintain or reassume responsibility for the management of mothers with complications; (3) recheck patients assigned to nurse-midwives at a specified interval, usually toward term (there was some disagreement here, some of the respondents believing that the nurse-midwives were capable of determining when reexamination by a physician was indicated); and (4) supervise the *midwifery* functions (as contrasted to the nursing functions) of nurse-midwives.
- There was essential agreement that the practicing nurse-midwife is capable of (1) providing complete antepartal care to patients assigned to her, as long as the pregnancies are normal; (2) managing normal labor; (3) conducting normal delivery; (4) providing immediate care of the newborn; and (5) evaluating and supervising the progress of normal post-partum mothers.

A substudy focused on the attitudes of the physicians toward nurse-midwifery. This was done to test the hypothesis that physicians who had had experience with nurse-midwives—as had all the physicians in the study—would have a highly favorable attitude toward the practice. The scores obtained from a series of attitude statements responded to by these physicians seemed,

in the opinion of the investigator, to prove the hypothesis.

A full report of the study will be published by the Children's Bureau in the near future.

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Concerned over (1) the limited types of experience available in the past to nurses who have desired to study midwifery in the United States, and (2) the scarcity of educational opportunities for professional midwives who need a sound orientation in the broad aspects of maternal and child health, including nursing, the Division of International Cooperation of the Children's Bureau, in cooperation with AID (Agency for International Development), is developing training opportunities for these nonmedical health personnel engaged in maternal and child health services.

Programs will be developed in cooperation with educational and service agencies for foreign nurses and midwives, to help them improve their administrative and teaching skills; to aid them in cooperating with their colleagues in the development of a comprehensive maternity service within their own countries; and to stimulate them to assume leadership for the education of future nurses and midwives.

Child Welfare

Children of women prisoners are the object of concern in a two-part study project being undertaken in California under the sponsorship of the State Departments of Social Welfare and of Corrections, with the assistance of the Jewish Committee for Personal Service, Los Angeles, and with the use of Federal child welfare services funds. The project is focused on the children and families of women in the State's only institution for women, the largest State penal institution for women in the United States. In August 1962, when its first phase, a preliminary study, was getting under way, the institution held 929 women, 520 of whom were the mothers of minor children—1,200 children in all.

This first study phase was completed last year and has been reported on in a monograph by Serapio R. Zalba in collaboration with Lois M. Tandy and Cynthia E. Nesbit. ("Women Prisoners and Their Families.") Focused on the relationship of the institution with community social agencies, its purpose was to develop understanding of the problems involved in designing programs to meet the social welfare needs of the families and children. Through analysis of official records and the use of questionnaires and personal interviews, data were gathered on the women, their children, and the agencies which had provided or were providing social welfare services to them.

The investigators found "few indications of family-oriented planning, especially for the future of the children," and little opportunity for person-to-person contact among staff members of different agencies which had worked with them. The children tended to be "unstable . . . exhibiting diffuse anxiety, apprehension, uncertainty," and, in general, had been moved around considerably, sometimes for years, experiencing previous separations from siblings as well as from parents. In many cases, when social agencies had attempted to arrange long-term foster care, the mothers had been bypassed in the formulation of the decision, and in the end had sabotaged plans.

The investigators recommended coordinated family-oriented planning between social welfare agencies and the institution to provide these families with assistance in the placement of children and in the development of realistic short-term and long-term family goals and plans; to provide the mother with assistance in working out her feelings toward her children in preparation for making long-term arrangements for care; and to arrange for referral of family members to appropriate social welfare resources.

A few copies of the monograph are available without charge from the California State Department of Social Welfare, 2415 First Avenue, Sacramento.

The second phase of the project—a demonstration to implement and evaluate procedures for carrying out these recommendations—is now under way.

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A plan to make emergency protective services available to children on a 24-hour, 7-day-week basis throughout of the State of Illinois was initiated early this year by the Illinois Department of Children and Family Services. For this purpose, the department established a telephone answering service in the State capital, Springfield, to accept and relay calls from and to any community in the State. Through this communication system, caseworkers in the department's eight regional offices who have been assigned to on-call duty after hours are informed of situations requiring their attention only a few minutes after a report of child neglect, abuse, or exploitation has been received.

The plan extends to nights and weekends, the protective service already being provided through the department's regional and branch offices during the day on weekdays: the provision of consultation to local officials and others concerned about situations involving the abandonment, abuse, neglect, or exploitation of children, and the emergency placement of children when immediate protective action is deemed necessary.

Mental Retardation

Early this year, the American Academy of Pediatrics issued a statement recommending that, before they are discharged from the hospital, all newborn infants be tested for phenylketonuria (PKU), an inherited metabolic disorder which, unless detected and treated, results in mental retardation. Through its Committee on Fetus and Newborn, the academy also urged that a second test for PKU be performed at 4 or 6 weeks of age to detect infants with borderline or low levels of phenylalanine—the amino acid which babies with PKU are unable to metabolize. The committee further recommended that all newborns be tested for two other inherited metabolic disorders, galactosemia and fructosemia, which, interfering with the body's ability to utilize certain types of sugar, may lead to retardation or death.

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Concern about the difficulties parents of mentally retarded children experience in getting dental care for their children prompted the Children's Bureau and the University of Tennessee College of Dentistry to hold a 2-day meeting of experts in child dentistry on March 8–9, 1965, at the college in Memphis, as a first step in developing guidelines in care of the mentally retarded child for the practicing dentist.

About 25 dentists from private practice and clinic programs attended, all with experience and special skill in the dental care of handicapped children.

Preliminary guidelines based on the points presented in the March meeting are being prepared as a basis for discussion at a regional working conference to

be held sometime within the next few months. At this conference, also to be held in Memphis, representatives from public health departments, dental schools, and private dental practice from six States in the southeastern region of the United States (DHEW Region IV) will come together to determine the final content of the guidelines. These will be presented in a publication to be issued by the Children's Bureau shortly thereafter in an effort to motivate the dental profession to provide more services of high quality for mentally retarded children.

ICY and Youth

A Youth Activities Committee was set up in the Federal Government in mid-March as one of the 28 committees working on observance of International Cooperation Year, designated by the United Nations General Assembly as 1965 to coincide with the U.N.'s 20th anniversary, and proclaimed by the President on October 2, 1964. Each of these committees consists of a chairman from the Government department most directly involved in the subject of the committee and members representing departments or agencies having an interest in the committee's area of concern.

The chairman of the Youth Activities Committee (YAC) is James M. Quigley, Assistant Secretary of the Department of Health, Education, and Welfare, who represents the Department on the Cabinet Committee on International Cooperation Year. Helen K. Mackintosh, Chief of the Elementary School Organization Section in the Office of Education is co-chairman.

This committee, defining "youth activitips" broadly, and working through the structure of the Interdepartmental Committee on Children and Youth, and its Executive Secretary, Mary E. Blake, will (1) make an inventory of international cooperative youth activities now carried on in each agency represented by its membership; (2) develop recommendations for new areas of cooperation or for expanding existing international activities; (3) look for ways to increase public understanding of the scope and effectiveness of U.S. activities in the international field: and (4) prepare a working paper for a White House Conference to be held November 29–December 1, 1965.

The YAC will work with a counterpart nongovernmental Citizens' Committee, which has been established by the United Nations Association. The chairman of the YAC Citizens' Committee is Rev. James H. Robinson.

Among the 27 other Federal committees concerned with International Cooperation Year are committees on education and training, welfare, and health.

Guides and Reports

STRATEGY OF CHANGE: Summary of Joint Conference on Children and Youth, April 5–8, 1964. Washington, D.C. National Committee for Children and Youth, 1145 19th Street NW., Washington, D.C., 20036. 1964. 48 pp. Mimeographed. $1.25.

Contains the reports of the constituent groups—the Interdepartmental Committee on Children and Youth, the National Council of State Committees for Children and Youth, and the Council of National Organizations for Children and Youth—the major addresses, and a Conference Summary. The theme: "Translating New Concepts Into Services for Children and Youth."

ENTERIC INFECTIONS: Report of a WHO Expert Committee. World Health Organization Technical Report Series No. 288. Geneva, Switzerland. Columbia University Press, International Documents Service, 2960 Broadway, New York, 10027. 1964. 36 pp. $1.

This report of a 1963 meeting on "the most important cause of sickness and death among children" in many of the developing countries discusses the complex interrelation of biological, social, and economic factors involved in the persistence of enteric diseases.

OPENING NEW DOORS TO THE CEREBRAL PALSIED THROUGH DAY CARE AND DEVELOPMENT CENTERS. Elsie D. Helsel, Sherwood A. Messner, and L. Leon Reid. United Cerebral Palsy Associations, 321 West 44th Street, New York, 10036. 1964. 50 pp. Single copies available free on request from UCPA.

A guide for the operation of day-care centers and development classes for severely and multiply handicapped children, teenagers, and adults.

PUBLIC WELFARE: POVERTY—PREVENTION OR PERPETUATION; A Study of the State Department of Public Assistance of the State of Washington. Greenleigh Associates, Inc., 355 Lexington Avenue, New York, 10017. 1964. 277 pp. $5.

This comprehensive study of a State's public welfare program examines its various programs, their structure, and methods of operation against the current needs of families and children within the State and the availability of other resources for meeting them.

FEDERAL AGENCIES FINANCING RESEARCH: The 1964–65 Guide to Government Grants and Contracts. Social Legislation Information Service, 1346 Connecticut Avenue NW., Washington, D.C., 20036. Revised edition. Document 18. 1964–65. 34 pp. $2.

Describes 48 research grant and contract programs administered by agencies of the Federal Government, 9 of them authorized under public laws passed by the 88th Congress in 1964 or late in 1963.

REPORT OF THE 1964 NATIONAL CONFERENCE ON HOMEMAKER SERVICES, April 29–May 1, 1964, Washington, D.C. Virginia R. Doscher. National Council for Homemaker Services, 1790 Broadway, New York, 10019. 1965. 76 pp. $1.

Reports on the needs and status of homemaker services today, as revealed in the more than 80 papers presented at the conference.

BOOK NOTES

THE DEVELOPMENT OF MOTIVES AND VALUES IN THE CHILD. Leonard Berkowitz. Basic Books, New York. 1964. 114 pp. $2.95.

Pointing out that his book is concerned with "socialization—the process by which children learn to become adult members of their society," the author, professor of psychology at the University of Wisconsin, focuses on two specific aspects of child development—achievement motivation and moral development—and summarizes recent findings of research regarding cultural, religious, social-class, and familial influences on each. He also gives attention to the role of the child's identification with his parents and to the question of the operation of motives and values in governing behavior.

The studies he has evaluated "add up," he says, "to one important point"—namely, that parents who want their children to be "reasonably successful" must take an active part in developing in them appropriate values and motives. Children's wishes cannot be indulged in the hope that they will then "automatically develop the desired motives and values," which must be, on the contrary, "deliberately inculcated."

If everyone could formulate his own moral standards without regard to the needs of others, concludes Professor Berkowitz, "we would have . . . anarchy."

DEVELOPMENTAL DYSLEXIA. Macdonald Critchley, M.D. Charles C Thomas, Springfield, Ill. 1964. 104 pp. $5.50.

Dr. Critchley, senior neurologist, King's College Hospital, London, and senior physician, National Hospital, London, has written a detailed study of a serious impairment of the reading faculty.

Both children and adults are subject to this condition, the medical term for which is developmental dyslexia. The popular, and more revealing, name is congenital wordblindness.

Although Dr. Critchley lists some 165 studies of dyslexia in the bibliography, specialists are by no means in agreement as to its etiology.

But, writes Dr. Critchley, "The outlook is anything but hopeless. With appropriate tuition, dyslexics can make considerable progress and they may attain sufficient ability to read for all practical purposes."

The need for better understanding of this impairment is stressed in this book in a quotation from the writings of Dr. James Hinshelwood, an early student of dyslexia, who wrote in 1902:

"It is a matter of the highest importance to recognize the cause and the true nature of this difficulty [when] experienced by . . . children; otherwise they may be harshly treated as imbeciles or incorrigibles, and either neglected or punished for a defect for which they are in no wise responsible."

SCHOOL READINESS: Behavior Tests Used at the Gesell Institute. Frances L. Ilg and Louise Bates Ames. Harper & Row, New York. 1965. 396 pp. $7.95.

The basic educational viewpoint of the Gesell Institute of Child Development, as described in this book, is that children should be entered in school—and therefore grouped and promoted—on the basis of their developmental or behavioral age, not on the basis of their chronological age or IQ. The authors, Dr. Ilg and Dr. Ames, are, respectively, the director and the research director of the institute, which was founded in 1950 in honor of the late Dr. Arnold Gesell.

They describe a study (initiated in 1957 with the support of the Fund for the Advancement of Education) in which they held interviews with 100 children, age 5 to 10, in 2 school districts in the Connecticut community of North Haven.

The basic tool used in these interviews was a specialized, seven-part "developmental examination," designed at the institute, through which the child is enabled "to reveal himself as a total individual, telling us about his level and method of growing and his state of readiness for the different stages of the educative process." They maintain that the child's behavior level, as determined through such an examination, offers "the correct clue to good grade placement."

Samples of all the "developmental examination" test forms are printed in an appendix, together with instructions on how to give the tests, evaluate them, and make use of the results. "Test Materials and Recording Sheets to Accompany SCHOOL READINESS" may be purchased separately for $4 from Harper & Row, 49 East 33d Street, New York City, 10016.

CARE OF CHILDREN IN DAY CENTRES. Public Health Papers No. 24. World Health Organization, Geneva. Available through Columbia University Press, International Documents Service, New York, 10027. 1964. 189 pp. (Paperback.) $2.25.

The nine papers in this volume describe the administrative, health, and psychological aspects of day-care centers and other child-care facilities in various countries, as well as the effects these services have on the child and his family. The emphasis is on the physical, social, intellectual, and emotional needs of children at various stages of development and the relation of these needs to the types of facilities provided, their location, and the daily program and activities.

Contributors include specialists in pediatrics, mental health, child development, and public health administration from Sweden, Germany, France, the United States, and Poland; and the International Labour Office. The paper by ILO presents trends in the employment of women—especially those with children—in various regions of the world, and the various types of facilities needed by working mothers.

DR. MONTESSORI'S OWN HANDBOOK. Maria Montessori. Robert Bentley, Inc., Cambridge, Mass. 1964. 121 pp. $5.

This is one of a growing number of republications of the works of Maria Montessori, originator of the Montessori method of preschool education. The book is of interest because of the many proposals for use of Montessori methods in preschool education programs today.

IN THE JOURNALS

Day Care

In the March 1965 issue of *Child Welfare*, a "Special Issue on Day Care," Milton Willner, associate director of a family day-care project in New York City, maintains that the profession of child welfare has confused maternal deprivation with separation, and, contrary to the evidence, according to his view, has equated multiple mothering with deprivation. ("Day Care: A Reassessment.")

Examining the "basic question" of why day care is not more readily available to the children of working mothers in the United States today, Mr. Willner holds that this lack is the result of the "traditional reluctance" of the social work profession to separate mother and child, and the profession's failure to recognize the need to *plan* for the care of children of working mothers. Day care, he says, is not a substitute for any other service, but has unique values of its own in (1) providing the child with a variety of everyday experience that forms a basis for wider learning and expression; and (2) fostering a child's capacity for later learning. Any and all young children should be accepted into day-care programs, he concludes, because this would provide both education for the children and constructive, refreshing relief for the mother during part of the day.

Other articles in the issue describe a research-oriented day-care center in Syracuse, N.Y., for children from 6 months to 3 years of age, aimed at fostering their subsequent educability; a project to provide mental health consultation to teachers in three day-care centers in New York City; and a day-care center in Cincinnati, Ohio, "that blends education and social work" to help low-income families.

The Case for Counsel

In a discussion, in the January 1965 issue of the quarterly *Crime and Delinquency*, of whether the offender in a juvenile proceeding has a right to counsel, Eugene E. Siler, Jr., concludes that "the most important right and the one that should be absolute is the right to assistance of counsel, through whose efforts any abuses of the court can be properly handled. . . . The child has a right to counsel, court-appointed when necessary; unless he has counsel to advise him properly, he does not have a true hearing." ("The Need for Defense Counsel in the Juvenile Court.")

The author does not base his conclusion on constitutional grounds, explaining that, since "juvenile proceedings are not criminal in nature but are an adjudication upon the status of the child and are a type of guardianship imposed by the state *in parens patriae* [the State as legal guardian], constitutional safeguards guaranteed to one accused of crime are not applicable to juvenile offenders." Rather, he bases his conclusion on application of "due process of law and fundamental fairness, while still retaining for the juvenile proceeding the whole theory of *parens patriae*."

He maintains that most lawyers who appear in juvenile courts do not fully understand the proceedings, partly because of the paucity of law school courses on such proceedings.

Transfusion in Utero

A new technique of transfusion delivered *in utero* to save fetuses with hemolytic disease (*erythroblastosis fetalis*), developed and first practiced in January 1964 by Dr. A. William Liley, of the National Women's Hospital, Auckland, New Zealand, has salvaged, to date, "about two out of three . . . formerly hopeless pregnancies," and "In the U.S., . . . could . . . save as many as 3,000 babies a year," according to an article in the January 1, 1965, issue of *Medical World News*. ("Saving Life Before Birth.") Since his first such operation, Dr. Liley has repeated the process over 40 times and other practitioners have performed some 60 similar operations on 4 continents, the article reports.

Erythroblastosis fetalis, the article points out, usually afflicts the offspring of Rh-negative women who, married to Rh-positive men, have become sensitized to the Rh-positive blood of previous fetuses. In the technique described, about 200 millimeters of Rh-negative blood are injected through the mother's abdomen directly into the fetal peritoneum to provide enough added vitality to tide the baby over 2 or 3 crucial weeks to safe delivery.

Dr. Liley described the technique at a meeting devoted exclusively to intrauterine surgery, held at Stowe, Vt., late in 1964 under the auspices of the National Institute of Child Health and Human Development and the University of Vermont. He is at the College of Physicians and Surgeons, Columbia University, on a fellowship from the National Institutes of Health, working on problems of placental physiology.

AFDC Groups

The practice of holding regular meetings of small groups of 6 to 10 recipients of aid to families with dependent children, to help them build constructively on their own inner strengths and to emerge from their "appalling" social isolation, is described by Louise C. Youngman, district supervisor, Department of Public Welfare, Baltimore, in the January 1965 issue of *Public Welfare*. ("Social Group Work in the AFDC Program.")

The article reports that in weekly hour-long group discussions, with a trained social group worker in charge, mothers, and some fathers, have discovered that they are not alone with their problems of coping with inadequate income, unemployment, broken family relationships, community hostility, and the difficulties of maintaining satisfactory homes for their children. Group members are selected on the basis of common problems, such as mothers who have been unsuccessfully seeking employment; mothers of children adjudged to be delinquents; or mothers with physically incapacitated husbands.

In a detailed summary of one group's proceedings, the author quotes a mother as saying that the group helped her "to say things and ask questions" which she would have been afraid to bring up outside the group; and another as saying that it gave her "the first chance she'd ever had to talk about 'deep things.'"

Maintaining that the social group work method "offers AFDC parents . . . an opportunity to achieve a sense of

self-worth and belonging," the author pleads for more trained group workers in the AFDC program.

The Hospitalized Child

Noting that in some retrospective case histories of children who have been hospitalized, "lasting neurotic patterns" have been traced back to the time of their hospitalization, Dr. Edward A. Mason, in the February 25, 1965, issue of *The New England Journal of Medicine*, calls attention to six ways of preventing or alleviating the traumatic effects of hospitalization on children. ("The Hospitalized Child—His Emotional Needs.")

1. *Avoidance of hospitalization.* The author notes that home-treatment services maintain children's normal environment; that more thought is now being given before prescribing elective operations; and that fewer children are being hospitalized for routine evaluations.

2. *Preparation.* The author holds that an honest parental account of anticipated events can reduce the "strangeness" of hospitalization for the child.

3. *Physical arrangements.* Dr. Mason notes that many hospitals now make their wards more homelike, with gay decorations, the provision of toys, play areas, and a central dining table for ambulatory children.

4. *Liberalized visiting by parents.* According to Dr. Mason, older patterns of limiting parents' visiting have given way, in many hospitals, to "a variety of patterns that allow flexibility."

5. *Mother staying with child.* Recognizing that separation from the mother is the chief traumatic factor for many hospitalized children, the author stresses the "therapeutic uses" of admitting mother and child together, the mother remaining through all treatments, tests, and examinations.

6. *Staff relations.* The author emphasizes the importance of an honest and comforting approach to the child.

Development of Conscience

Using four brief stories (a "Fight Story," a "Cup Story," a "Lost Story," and a "Scout Story"), Martin L. Nass of Brooklyn College recently investigated the development of conscience in deaf and hearing children, as reflected in the moral judgments made by them of the stories' contents. Mr. Nass, who carried on his research with the help of a fellowship from the National Institute of Mental Health, has reported on his investigation in the December 1964 issue of the quarterly *Child Development*. ("Development of Conscience: A Comparison of the Moral Judgments of Deaf and Hearing Children.")

Thirty children, six at each age level from 8 to 12, all congenitally deaf and of average or slightly superior intelligence, were told the four stories. Questions were then asked: How do you think Louis felt about it? Should both boys be punished? Should one be punished more? The answers given were compared with those given to the same materials by 30 hearing children in a previous test conducted by Mr. Nass and a collaborator.

Mr. Nass concluded from his data that the conscience of deaf children matures slightly earlier than, or at about the same age as, children with normal hearing in "response to situations involving independence from adults and peer reciprocity;" that hearing children under 12 indicate significantly greater maturity in situations involving recognition of the distinction between motivation and the results of an action; but that by the age of 12, there are no measurable differences in conscience development.

READERS' EXCHANGE

STRINGER: ***An ethical question***

The January-February 1965 issue of CHILDREN contained a two-part article entitled "Homemaker Service in Neglect and Abuse." (Part I—"Strengthening Family Life," by Louise Foresman; and Part II—"A Tool for Case Evaluation," by Elizabeth A. Stringer.)

Miss Stringer writes: "These acts range from battering a child in impulsive rage to deliberate intent to murder. In such situations, the use of homemaker service to assist a social caseworker in the evaluation of family strengths and weaknesses, and to provide facts based on direct observation, can be invaluable in helping a responsible agency to take appropriate action for the protection of the child."

May I ask, "What is the 'appropriate' action to be taken by the agency?" If it is court action for custody of the child, the information via the homemaker would be hearsay, unless the homemaker agrees to testify directly. If that is the case, it poses an ethical question for an agency to place a homemaker to secure evidence.

In commenting on a case of a 9-month-old boy who was made a hopeless cripple by his father's rage, Miss Stringer states: "Even when his father acknowledged the acts that resulted in Paul's becoming a hopeless cripple, the legal, medical, and social professions were reluctant to heed this family's unspoken appeal for Paul's protection."

In response to this statement, I would say our society has failed miserably to construe such action as an appeal for help. Let us rather think of the basic constitutional right of a child to grow up. I think we should refresh ourselves by rereading the Children's Charter (1930) and act with those goals in mind.

Finally, I see homemaker service as a tool for rehabilitation which should be used *after* a careful evaluation by those who claim competence to make judgments as to its use in a particular situation. I think Mrs. Foresman, in Part I, illustrates this very well.

Elvira G. Ager
Project Administrator, Eau Claire County (Wis.) Youth Study

Author's reply

The use of homemaker service in the diagnostic assessment of parental func-

tioning is by no means a new concept, but it is only recently that we have clearly stated this to be one of its primary uses. However, in no instance is a homemaker assigned without the family's full knowledge of the purpose of the service, complete acceptance of it, and stated willingness to participate. Fortunately, as Mrs. Foresman has indicated, in many instances the placement of a homemaker can improve family functioning through example and direct teaching. Or, the support and encouragement of a homemaker may enable the caseworker to help an exhausted, yet guilt-ridden, mother come to a decision to institutionalize a severely retarded child, thus freeing her to devote her energies more appropriately to the rest of her family.

Occasionally the combined services of the homemaker and one or more professional persons are insufficient to redirect well-established patterns which are serving to meet the pathological needs of the parents. When all other methods have been tried and have failed, intervention becomes the only means of protecting the child, as in the case of "Paul."

Some professional soul searching has been necessary to feel comfortable with this concept, not only in regard to parental rights and civil liberties, but also in requiring homemakers to observe, record, and to testify. There are several excellent articles relative to this subject; among them the three papers compiled in the Child Welfare League of America's publication, "The Neglected Battered-Child Syndrome; Role Reversal in Parents." The knowledge that 22 States now have laws making it mandatory for doctors and hospitals to report cases of suspected child beating lends heartening support to our conviction that the life of a child must be the primary focus of our concern and action.

Elizabeth A. Stringer
Associate Director, Foster Care Services, Children's Aid Society, New York

HERZOG AND BERNSTEIN: ***A disappointing omission***

The article "Why So Few Negro Adoptions?" by Elizabeth Herzog and Rose Bernstein, in the January–February 1965 issue of CHILDREN, makes several important comments on the problems of placing Negro children for adoption. It is well that the presumption that Negroes are not "doing their share" of adopting is exposed as erroneous. The authors suggest that Negroes above the poverty margin of $3,000 are apparently adopting children at a higher rate than whites.

A disappointing omission in this article was the complete ignoring of adoption agency efforts, either already under way or planned, to place nonwhite children in white families. To be sure, no significant number of Negro or part-Negro children have been placed in white families. However, several agencies have undertaken efforts to recruit white families to adopt minority-race children, with gradually increasing success.

For example, a 2-year recruitment project in Minnesota, financed from Federal child welfare services funds, called PAMY (Parents to Adopt Minority Youngsters), shifted its focus, after the first year's operation, from recruiting adoptive homes from among the minority races to recruiting in the community in general in behalf of minority-race children. Several white families have adopted part-Negro children. Agency staff members and board members have increasingly accepted and encouraged the appropriateness of such placements. Agencies in other States are turning their efforts in this direction.

The authors of "Why So Few Negro Adoptions?" point to the need for agencies to modify their policies and practices. Such modification should include the possibility of interracial placement.

Why should we presume that a child who is "part-Negro" should be placed only in a Negro family? After all, the child is most likely also "part-white."

With the increasing emphasis today on human relations, nondiscrimination, and racial integration, the climate is progressively improving for interracial adoption.

Charles B. Olds
Executive Director, Children's Home Society of Minnesota, St. Paul

A neglected potential

The earnest recommendations of Elizabeth Herzog and Rose Bernstein are pathetic in view of something like 16 times as many potentially qualified white families to take these kids as there are potentially qualified nonwhite families. (This ratio is based on Herzog's and Bernstein's age under 45 and over $3,000 qualification criteria.)

Are Miss Herzog and Mrs. Bernstein unaware of this potential?

Robert R. St. John
St. Paul, Minn.

"Infuriating"

I found the Herzog and Bernstein article infuriating.

All the facts are carefully documented and clearly presented. Then, the obvious conclusion is completely ignored: white adoptive homes for Negro children.

Rex Ragan
Foster Home Recruitment Director
Los Angeles County (Calif.)

FOR PARENTS

CARING FOR YOUR DISABLED CHILD. Benjamin Spock and Marion O. Lerrigo. The Macmillan Co., New York. 1965. 373 pp. $4.95.

HOW TO SURVIVE PARENTHOOD. Eda J. LeShan. Random House, New York. 1965. 242 pp. $4.95.

HOW TO GUIDE YOUR SCHOOL-AGE CHILD. Leland E. Glover. Foreword by C. C. Trillingham. The Macmillan Co., New York. 1965. 285 pp. 95 cents.

NOBODY SAID IT'S EASY. A practical guide to feelings and relationships for young people and their parents. Sally Liberman Smith. The Macmillan Co., New York, 1965. 223 pp. $4.95.

YOUR ALLERGIC CHILD. Easy-to-understand guide for parents. Herman Hirshfeld. Arco Publishing Co., 219 Park Avenue South, New York, 10003. 1965. 142 pp. $1.45 paperback; $3.25 clothbound.

WHAT TO TELL YOUR CHILDREN ABOUT SEX. Prepared by the Child Study Association of America. Foreword by Milton I. Levine, M.D. Duell, Sloan & Pearce, New York. Also available from the Association, 9 East 89th Street, New York, 10028. Revised 1964. 117 pp. $2.95.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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DAY CARE SERVICES: Why? What? Where? When? How? Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 420. 1964. 44 pp. 25 cents.

Addressed to parents, civic groups, and others interested in strengthening community day-care services for children, this illustrated pamphlet shows: why day-care services for children are needed; what types of services should be available to meet the individualized needs of parents and children; the kinds of staff they need; what kinds of supplementary services are required; and how the appropriate services can be developed and coordinated.

WHAT IS GOOD DAY CARE? Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 53. 1964. 11 pp. 15 cents.

Directed to parent groups and community leaders and agencies, this pamphlet describes the ingredients of good day-care services for children, explains the reasons some children need such services, and offers guidelines for getting a day-care program under way.

YOUR CHILD FROM 1 TO 3. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 413. 1964. 21 pp. 20 cents.

The second in a series of pictorial guides designed for quick and easy reading by parents of young children, this pamphlet highlights the points on child care that parents need to know and consider.

YOUR PRESCHOOL CHILD'S EYES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 54. 1964. 15 pp. 15 cents.

Written for parents, this pamphlet recommends inclusion of a professional eye examination in the preschool checkup of every child by age 3, even though he has no obvious eye abnormality or visual problem. It also describes the symptoms of eye trouble in both preschool and older children which call for immediate examination when discovered by the parents.

THE CLINICAL TEAM LOOKS AT PHENYLKETONURIA. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. Revised 1964. 56 pp. 40 cents.

All the papers in this revision of a 1961 publication have been rewritten by the original authors—six members of a multidisciplinary clinical team—to present their extended observations on phenylketonuria and the problems encountered in providing services to the affected child and his family. The authors include a biochemist, a pediatrician, a medical social worker, a public health nurse, a psychologist, and a nutritionist.

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